ARE WE MEETING THE HEALTH CARE NEEDS OF MICHIGAN'S RURAL ELDERLY?

JOINT HEARING

BEFORE THE

SELECT COMMITTEE ON AGING

AND THE

TASK FORCE ON THE RURAL ELDERLY

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

MAY 12, 1986, HOUGHTON LAKE, MI

Printed for the use of the Select Committee on Aging

Comm. Pub. No. 99-581

U.S. GOVERNMENT PRINTING OFFICE
62-069 O WASHINGTON : 1986

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

H141-51

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ARE WE MEETING THE HEALTH CARE NEEDS OF MICHIGAN'S RURAL ELDERLY?

MONDAY, MAY 12, 1986

House of Representatives,
Select Committee on Aging, and the
Task Force on the Rural Elderly,
Houghton Lake, MI.

The committee and task force met, pursuant to notice, at 9:15 a.m. in the community center, Houghton Lake, MI, Hon. Bill Schuette (acting chairman of the committee) and Hon. Thomas J. Tauke (acting chairman of the task force) presiding.

Members present: Representatives Schuette and Tauke.

OPENING STATEMENT OF REPRESENTATIVE BILL SCHUETTE

Mr. Schuette. This hearing of the Select Committee on Aging and the Task Force on the Rural Elderly will now come to order. And let me first say, again, good morning to all of you, and thank you for coming, in some instances, great distances, and getting up, certainly, very early in the morning. I'm just pleased and very grateful that you've all come here to this meeting. I also would be remiss if I didn't thank the people here at the Houghton Lake Community Center, and Tina Berry who's been so cooperative and helpful with this hearing, and in the past, as well.

Ladies and gentlemen, this is an official hearing of the Select Committee on Aging and the Task Force on the Rural Elderly, concerning, "Are We Meeting the Health Care Needs of Michigan's Rural Elderly?"

This morning, we'll have three panels of distinguished men and women who are active in health care, and in the concerns of our senior citizens and our retirement community in the State of Michigan.

We will hear testimony from providers, hospital administrators, representatives from nursing homes, and health care agencies, plus individuals who have been playing such a large role in county councils on aging, and the area agencies on aging in Michigan.

In addition, we will hear testimony from Medicare beneficiaries who have received health care services in our area.

This is an effort to bring government to people. This is an effort to hear directly from men and women who have great expertise, knowledge, and skill in dealing with the question of whether we are meeting the health care needs of Michigan's rural elderly.

I'm honored to chair this important Aging Committee hearing on the health care needs of Michigan's rural elderly. It is an issue that concerns all of us, seniors, families, health providers, and our society as a whole. The problems of the rural elderly are distinct from others, and it is for this reason that I have called together these witnesses and my colleague, Congressman Tom Tauke, from the State of Iowa, so that we may learn, firsthand, the unique problems in the 10th Congressional District of Michigan.

And let me add, at this juncture, that Mr. Tauke is a good friend of mine, an esteemed colleague, who represents a rural district in the State of Iowa, not unlike our district of mid-Michigan. We serve together on the Select Committee on Aging, and Mr. Tauke, as well, serves on the Energy and Commerce Committee.

Tom brings to this hearing a prospective from a rural State that has many of the same economic concerns as we have. And, in addition, Tom served in the Iowa State Legislature prior to coming to Congress in 1979. So, let me welcome you to God's country, Congressman Tauke. And that's how we refer to this part of Michigan, because it indeed is a chosen place.

As we begin this hearing, I'd like to acknowledge several important events. As you may know, tomorrow our State Government will honor Michigan's greatest resource, our older population, at the Senior Power Day festivities. And for the information of those in our audience, Mrs. Rosella Newman, as well as many others, has been instrumental in this effort.

In addition, Congress has designated the month of May as Older American's Month. And this week of May 12, has been designated National Senior Citizens' Centers' Week.

The proportionate number of persons over 65 has grown, and will continue to grow, more rapidly than any other age group. In the last two decades, the older population grew twice as fast as the rest of the population. In Michigan, there are over 1 million seniors over the age of 65. And this is 11.1 percent of our total population. This figure represents a 10.3 percent growth in the number of senior citizens in Michigan since the 1980 census. Nationwide, by the year 2000, half of the elderly population is expected to be 75 years of age, or older. And close to two-thirds of all of the 65 year and older males will be veterans, and eligible for health care benefits.

It is probably no surprise to most of us that the elderly are the heaviest users of health services. Additionally, those in rural, more remote areas, often face great financial and emotional difficulty in obtaining adequate health care. It appears quite obvious that we must work together now to solve these problems.

I have talked with Medicare patients, their loved ones, hospital administrators, such as our two panelists here, today. Mr. Smith, from the 42-bed Gladwin Area Hospital, and Mr. Pattullo, from the 90-bed Tolfree Memorial Hospital in West Branch, and representatives of many senior organizations on this vital matter of providing quality and cost-effective health care for our senior citizens.

I am deeply concerned about the impact of changes in the Medicare Program, on the ability of physicians, hospitals, and other health care providers to assure continued availability of high-quality health care for Medicare beneficiaries. A few moments ago, I mentioned two rural hospitals that continue to provide excellent health care in the face of low Medicare reimbursement payments, and reduced Federal Medicare expenditures. I have worked diligently, along with Mr. Tauke, to correct the serious inequities in Medicare, which threaten our Nation's rural hospitals, and the quality of health care for our Nation's elderly. It is crucial that our hospitals, from the 21-bed Kalkaska Hospital, to the 188-bed Memorial Hospital in Owosso, remain financially sound in order to continue to provide quality health care for Michigan's elderly population.

Too many seniors, we've seen, have been discharged early. Some were sicker when they were discharged because of the inherent incentives in the Medicare prospective payment system not to provide care, in order to cut costs.

This morning, we will learn from several seniors who have been discharged early due to Medicare's inherent incentives to cut costs by shortening hospital stays. And where, and to whom, do the frail and sickly seniors turn when they're discharged? Without adequate community based services, such as home-delivered meals and housekeeping services provided by Michigan's area agencies on aging, and councils on aging, many rural elderly would suffer. Without home health care and nursing facilities, where else would senior's turn when health care providers are forced to turn them away, due to often inflexible Medicare regulations.

Congress has enacted several provisions designed to assure quality health care for seniors, while providing much-needed increases in reimbursements to hospitals serving Medicare beneficiaries. We have taken some positive steps, but we have a large task ahead of us. And I'm convinced, however, it's one we'll solve together.

I look forward to my colleague, Congressman Tauke's comments, and those of our distinguished panelists. Before I go further, Mr. Tauke will make a statement, and then I'll introduce our first panel of witnesses.

Mr. Tauke.

STATEMENT OF REPRESENTATIVE THOMAS J. TAUKE

Mr. TAUKE. Thank you very much, Mr. Chairman. When I think of God's country, I always think of northeast Iowa. I guess God is happy to claim Michigan as well as Iowa——

Mr. SCHUETTE. Yes, he is.

Mr. TAUKE [continuing]. As part of his country. It is good to be here this morning, especially in the district of Congressman Bill Schuette. Before coming here, when I thought about Michigan, I always hearkened back to those nice Saturday afternoons in the fall, when the Hawkeyes rolled over the Wolverines or the Spartans. But, today I find that Michigan is a beautiful place, with wonderful people. And I should have known that, because of your excellent representative.

There are lots of things that a Member of Congress could do on a Monday, besides come to a field hearing on health care issues. But I am here, in large part, because of the great respect that I have for your new Congressman. Having been in Congress, now, for 7 years, I feel like something of an elder statesman, and I can tell you that we in Congress, have all been very impressed by the hard work, the dedication, and the real sense of caring that we find in

Bill Schuette. And so, Mr. Chairman, I am very pleased to be here, and to be in your district.

I think I observe one other thing. I've been to a lot of field hearings around the country over the last 7 years, and some of them aren't organized too well. But I've noticed when they're organized well, it's because there's a very good staff back in the district of that Member of Congress. And that usually means that that staff not only organizes hearings well, they also provide very good service to the people in the district. So, I think you're very fortunate to have a good congressional staff. I don't know if that's to Bill's credit or if it just happened, but he's got some great people here.

Some of us have been very frustrated, over the last several years, by the course of events in the health care field. When we adopted a prospective payment system, we knew, in Congress, that there would be some inequities in the system. And, in fact, over the last several years as this system has developed, it's become clear that there are very serious inequities, particularly those facing or confronting the rural elderly.

Congress has not been unaware of the problems that were likely to occur, nor has it been unwilling to take action to correct those problems. In fact, during the last several years, on occasion after occasion, Congress has, in legislation, mandated that the Department of Health and Human Services conduct various studies to try to figure out what can be done to correct the prospective payment system, particularly as it relates to rural hospitals. And to date, the Department of Health and Human Services has not issued one of those studies mandated by Congress.

That's one of the reasons that the task force on elderly and your Congressman, Bill Schuette, and a number of other Members of Congress have, in a sense, taken matters into our own hands. We're trying to find out for ourselves what the facts are, and what can be done to correct these problems, because the Department of Health and Human Services has not done what Congress has mandated that it do.

The rural hospitals are suffering, under the prospective payment system, for a variety of reasons. First of all, they do not have the broad base of patients that allow them to go with the ebbs and flows of the prospective payment system. If you have a large base of payments, of course, as urban hospitals do, if you have one extreme case, you can absorb it among the others. Rural hospitals don't have that advantage.

Second, rural hospitals have a very high percentage of Medicare patients. I don't know exactly what the facts are in Michigan, although I expect we'll find out today, but in my home district, many of our rural hospitals have 60 percent or 70 percent of their patients as Medicare patients. So, they cannot afford to pass the Medicare costs on to their private pay patients, as some of their urban hospitals do.

Also, rural hospitals, we find, have had a much more rapid drop in patient days, a much more rapid drop in admissions, than some of their urban counterparts.

In addition, rural hospitals, under the prospective payment system, are just plain and simply getting shortchanged. In my own State of Iowa, we find that over the last several years, we have had a really major differential between the payments made to urban hospitals and to rural hospitals, for providing the exact same service. The labor reimbursement portion of the DRG component for hospitals has a differential of 23 percent in the State of Iowa. In other words, for the labor portion of the reimbursement, an urban hospital will receive 23 percent more than a rural hospital. But the nonlabor portion of the component in Iowa, a rural hospital receives 54 percent less than an urban hospital.

Or, putting it another way, if you have an appendectomy in an urban hospital in Iowa, and you have an appendectomy in a rural hospital in Iowa, the urban hospital will receive about a third greater reimbursement from the Federal Government under Medicare, than the rural hospital will, for the exact same procedure.

It is just not fair. But moreover, it is undermining the rural hospitals, and a very important component of the health care delivery system in rural America, because rural hospitals, in a very real sense, are the hub of the rural health care center. They provide many services, in addition to acute care.

For example, they usually provide skilled nursing care. They are the center for home health care. They provide adult day care programs, and in many instances, many preventive care programs.

Without a rural hospital, it is virtually impossible to attract physicians, or to retain physicians. And rural hospitals are, in many cases, the major employer, and the major source of economic activity in small communities.

And so, it is essential that we see they—that we produce policies to permit rural hospitals to survive and rural health care to flourish. That's why we are holding these hearings.

The system, to date—the prospective payment system—is harming our rural hospitals. It is also causing a deterioration in the quality of care for rural residents.

Congressman Schuette and I, and many other Members of Congress, believe that something needs to be done, in order to correct that problem. We have, over the past year, produced a number of pieces of legislation, some of which Bill has sponsored, and some of which he has cosponsored, in order to try to correct the problem. But we believe that in order to be successful in that effort, we have to compile the information from you and others, which will allow us to convince our colleagues to do what must be done.

I think it is relevant for us, today, to note that the Prospective Payment Assessment Commission, which looks at the whole health care delivery system and the way in which the Medicare payment system impacts upon it, has recently released a study, which talks about the problems proposed—or posed to rural hospitals by this prospective payment system. And let me just quote a couple of passages from this report, which emphasize, I think, very clearly the problem.

The report says, "in particular, the financial vulnerability of small rural hospitals to fluctuations in volume, and case mix have caused concern. For larger institutions, minor fluctuations in volume and case mix are less critical. Larger hospitals can average these fluctuations from year to year and over a large number of cases. Small, rural hospitals cannot take advantage of this law of large numbers. If such hospitals are located in relatively isolated areas, a deteriorating financial position results in closure of the facility. Medicare patients' access to services may be severely compromised. In the end, the Congress or the Secretary, or both, may have to determine whether it is appropriate to pay slightly more money, or pay differently, to avoid insolvency among certain rural hospitals. It may be cost-effective for Medicare to pay slightly more, or slightly differently, for care in these hospitals, if by doing so, rural patients are not required to seek care in distant, urban hospitals, where the care is less accessible and more costly."

We want high-quality, accessible care, for our senior citizens. We want to retain and strengthen the rural health care delivery system, and that's why we are holding this hearing.

Thank you very much, Mr. Chairman, for all of your work in getting these people and these witnesses here, and for inviting me.

[The prepared statement of Mr. Tauke follows:]

PREPARED STATEMENT OF REPRESENTATIVE THOMAS J. TAUKE

Are We Meeting the Health Care Needs of Michigan's Rural Elderly?

Mr. Chairman, I commend you for convening this very timely hearing on the question of how adequately our current Medicare program is meeting the health care needs of Michigan's rural elderly. As you are very aware, the House of Representatives will soon be grappling with budget proposals for next year. The testimony we receive today will provide us and our colleagues with whom we will share this testimony with guidance on the Medicare budget for next year and on policy changes which should be made to ensure that this program is more responsive to the health care needs of the nation's rural elderly. I am sure that the experience of Michigan's rural elderly is comparable to the experience of Iowa's and of the rural elderly nationwide.

Let me briefly outline the major issues with which Congress must grapple if we are to ensure that the rural elderly have access to high-quality, affordable, community-based health care services:

First, we must refine the prospective payment system for hospital reimbursement to correct inequities in the way in which rural hospitals are reimbursed. Rural hospitals are the hub of the rural health care system, and if they fail, the entire fabric of rural health care services is threatened. Many rural hospitals provide or serve as the locus for home health care services, skilled nursing care services, respite and adult day care services, preventive services, and a range of other health care services. It is difficult to attract physicians to or retain physicians in areas without hospitals. It is clear that the prospective payment system places rural hospitals at a distinct disadvantage in several ways:

(1) The current system is a numbers game that rural hospitals are simply not by their nature equipped to play. The prospective payment system assumes that hospitals will balance losses on the provision of care for some DRG cases against gains on the provision of care for others. Most rural hospitals don't have the volume of admissions necessary to balance losses. A few substantial losses can threaten the viability of rural hospitals.

(2) Part of a hospital's reimbursement is composed of a standardized federal payment for labor and non-labor costs. Rural hospitals are reimbursed less than urban hospitals for these costs on the assumption that rural hospitals experience lower costs than urban hospitals. This assumption is not correct for all rural hospitals, and particularly for those located near urban areas and experiencing costs comparable to nearby urban hospitals. A reimbursement methodology more sensitive to the variations in the actual costs hospitals experience must be developed, and in the interim, an appeal mechanism must be put in place to address inequities in reimbursement on a case-by-case basis. I have introduced legislation, H.R. 3767, to provide this appeal mechanism.

(3) Payments to rural hospitals for unusually high cost cases (outliers) must be improved. Currently, rural hospitals receive substantially less outlier reimbursement as a percentage of total perspective payment reimbursement than do urban hospitals.

Second, more must be done to ensure that the elderly continue to have access to care and receive high-quality care. Congress is receiving an increasing number of disturbing reports of senior citizens who are inappropriately denied admission to hospitals or who are discharged prematurely. We must make sure that every senior citizen knows that he or she has a right to appeal a discharge notice. We must also make very clear that the prospective payment system does not limit the number of days that patients may stay in the hospital for the treatment of illnesses. Unfortunately, many senior citizens have been frightened by false information they have received stating that their Medicare benefits will only cover hospital stays of a certain number of days for types of illnesses. Let me stress that this is not the case.

However, hospitals are under intense pressure to discharge patients as quickly as possible, since the hospital is now paid a set fee for treating illnesses. Congress is trying to ensure that quality and access are maintained under this reimbursement system by (1) increasing the quality control activities of the organizations under contract with Medicare to ensure that Medicare beneficiaries have access to high-quality care. These organizations, called Professional Review Organizations, are now reviewing many more discharges to detect any which may have been premature; and (2) ensuring that the prospective payment system is flexible enough to allow physicians and hospitals to respond to the differences in patient needs. Making rural hospital reimbursement more equitable for unusually high-cost cases will help to accomplish this.

Third, Congress must adjust our health care policies and programs to meet the growing and changing health care needs of our population and to hold down out-of-pocket costs for health care services. The elderly are living longer and remaining healthy longer, but are also confronting a longer period of chronic, debilitating illness at the last period of life. Many senior citizen with whom I have talked have told me of their desire to remain independent of institutionalization for as long as possible, which means that the demand for home health care services, homemaker services, and similar programs will continue to grow. Providing these services in rural areas involves greater challenges, considering transportation costs and the lesser availability of health professionals.

Catastrophic illness is another concern of the elderly which must be addressed by Congress. The elderly worry about how they will pay for a hospitalization which exceeds their Medicare coverage or for long-term care, should they need it.

Medicare does not cover the routine health care needs of the elderly, and these needs can consume a substantial portion of a limited income. Congress has received reports of many elderly going without needed prescriptions because they do not have the money to pay for them. The poorer elderly may have to do without new eyeglasses with more appropriate lenses or hearing aids, as a second example.

As we in Congress grapple with these issues and seek to ensure that the rural elderly's health care needs are being well-met, we need counsel from health care providers, from those who provide insurance coverage, from those associated with programs designed to meet the health care needs of the elderly, and most importantly, from the elderly themselves. That is why I am very pleased to be here today.

Mr. SCHUETTE. Thank you, Mr. Tauke. Even though he is from Iowa, he is OK ladies and gentlemen.

What I thought I would do at this opportunity is introduce four members of our first panel. Would Mr. Jeff York, and Mrs. Aletha Allen, Mrs. Marilyn Wonsitler, and Mr. Fred Corson come to our table to make their presentations, ladies and gentlemen?

As our panelists are sitting down, let me just explain that we will have three various panels. Again, from patients to senior advocates to health care providers. At noon, lunch is served here, and I have given my allegience to Tina that at noon we must cease and desist, because we must serve lunch here, and I think we all understand that. And so, what I would ask all of us is to try to make our 12:00 deadline so I stay on the right side of our director here, as well as the citizens who will be here for lunch.

Let me briefly introduce our panelists. Mr. Jeff York is a case manager from the Midland County Council on Aging. Mrs. Aletha Allen is a widow, who has been very active in senior activities, and will share with us some of her experiences on the early discharge question. Fred Colson, from the Prudenville area, will be, again, sharing some experiences he and his family have gone through. And then, Marilyn Wonsitler—also from the Midland area—will share with us her thoughts and concerns on health care delivery.

Ladies and gentlemen, let me say thank you for being here. I do have a copy of your statement, which will be in our printed record of the hearing. So what I might ask you to do is summarize briefly for us, and share with us, if you would, some aspects of your statement, and your full statement will be in the record.

Mr. York, would you care to lead off for us, please?

PANEL ONE: CONSISTING OF JEFF YORK, CASE MANAGER, MIDLAND COUNTY COUNCIL ON AGING; ALETHA ALLEN, SENIOR CITIZEN; FRED CORSON, SENIOR CITIZEN; AND MARILYN WONSITLER

STATEMENT OF JEFF YORK

Mr. YORK. Thank you. One of the main concerns of the elderly in regard to health care today is, of course, early release from the hospital. For many people, problems some more serious than others, arise as a result of early release. Some of the examples that have been related to me are following:

Mr. B was released to the hospital—or excuse me—was admitted to the hospital for minor day surgery and was heavily sedated by the anesthesia. Immediately after surgery, with no time allowed to check the affects of the anesthesia, his doctor instructed Mrs. B. to help Mr. B. get dressed and ready to go home. Mr. B. could not even sit up, much less stand on his own. After getting home, Mr. B. was disoriented for several days. Mr. B. feels he should have at least been warned of some of the side effects of the anesthesia.

Mr. M was released from the hospital approximately 7 days after having had quadrupal heart bypass surgery. He was sent home with seepage from the wounds, and packing in some of the openings. He does not recall any discharge planning having taken place. His primary caregiver had recently had a stroke, and caring for her husband complicated matters for her. Mr. M became very depressed. And after being home for 4 days, he was rushed back to the hospital, where one of the bypasses had to be redone.

Mrs. D was admitted to the hospital with a heart condition. She was released from the hospital without any discharge planning or rehabilitation, and was very weak. As a result, she was readmitted to the hospital within 24 hours, having fallen and injuring her back. She now has a chronic back condition.

Mr. K had been in and out of the hospital many times over the years with no complications. Then, in 1985, he was admitted to the hospital after having a stroke. After 13 days he was released, even though he could not swallow or eat because his throat was paralyzed. Five days later he had to be readmitted because he was not getting any nourishment. Two days after this he was taken to a skilled care unit with a feeding tube. Mr. K's condition continued deteriorating. Despite protests from Mrs. K that her husband had complications which were going undetected, she feels her concerns went unheeded and that little or no compassion was shown to her during her husband's stay in the hospital. After approximately 8 weeks in the skilled care unit of the hospital Mr. K passed away. Mrs. K feels very strongly this is a result of complications which arose during his stay in the skilled care unit of the hospital.

Mrs. L was admitted to the hospital with a broken hip; 3 weeks later she was taken to a skilled care unit where she spent 1 week. Although Mrs. L's daughter protested that her mother was not ready to go home, the hospital released her stating that Medicare had run out. The hospital, however, made Mrs. L's daughter sign a statement that she would arrange for 24-hour care in the home for her mother. This was not skilled care therefore not covered by Medicare and therefore created a financial burden for the family.

The simple fact is that there are a lot of seniors who are being released very early, and it is creating some real health concerns for them in their home.

Another result of the early releases from the hospital is that more and more seniors are requiring in-home type services, particularly during their recuperative period. For those who are unable to perform basic household chores on their own, these services are imperative.

One of the services, of course, is home delivered meals, which has seen a dramatic increase in the Midland County Council on Aging in the past several years. In 1984, 115 clients received home delivered meals. In 1985, this number increased to 192, a 67-percent increase. For 1986, it is projected our home delivered meals will increase 38 percent over the same period, as 1984.

It is important to keep in mind that, due to funding restrictions, it is not possible, at this time, to deliver the hot meals to all those in need, particularly those in the most outlying areas of the county. For these persons, we currently have what we call an emergency meal, which are canned or frozen goods. However, they do require heating and preparation, so they aren't quite as effective as the hot meals. Other alternatives require—would require hiring someone to prepare the meals for the seniors, a service not currently covered under Medicare. Or they have to rely on family or friends, which may or may not be present.

Our homemaking services, which allow for basic housekeeping tasks to be done, is also a program which more and more seniors are requiring, due to their early release from the hospital. Again, this service is not covered under Medicare. As the number of clients increase, less and less time will be available to be spent with each senior citizen in maintaining a safe and clean environment.

Case management is also a necessary program for persons who are discharged early, as it allows for the assessment of needs for inhome services. The case manager also assists clients in making decisions on changes in their living arrangements, and tries to involve families, as well as community services. Hospitals could link senior citizens with the case manager in order to make the transition easier.

Transportation, a vital service to senior citizens, becomes particularly important to those in rural areas, particularly for those facing early discharge from the hospital. Often, family or friends are not available to take a released senior home. When little or no notice is given, the senior may have great difficultly in arranging for a ride. Midland County is fortunate, in that we, the Council on Aging, does have transportation available to these Seniors, but we do require at least 24 hours notice in most cases. Federal funding cuts, however, may even affect this service.

One of the sadder facts concerning seniors who are facing early discharge from the hospital, is that many are not aware of the rights of Medicare recipients. I receive many calls from patients and concerned family members asking what, if any, alternatives they have to early discharge. I explain to them their right to proper care, the right to information in decisions affecting their Medicare coverage or the length of their stay, and their right to appeal the decision to a Federal peer review organization. For some reason, hospitals seem not to be getting these facts across to the recipients.

As long as the system of DRG's is in effect, it is particularly important that there be advanced discharge planning so that the hospitals can link their released patients to community services, or at least to the case management program.

It is crucial that funding be available to provide services in the home, such as case management, home delivered meals, and homemaking, and that transportation be available to those facing early discharge. With Gramm-Rudman, it is possible, however, that Older Americans Act money, which funds these necessary services, will be cut, at a time when the need is dramatically increasing.

Finally, it is important that hospitals inform Medicare patients of their rights while they are in the hospital, so that they are able to make adequate decisions and arrangements regarding their stay, and after they are discharged from the hospital. Particularly, it is important that funding be available to alleviate the financial burdens that occur for senior citizens or for their families when any type of inhome service must be provided.

Thank you.

Mr. SCHUETTE. Thank you very much, Mr. York. I think we will proceed now. Mrs. Allen. I thank you for your fine testimony, Mr. York.

Mrs. Allen, we have a copy of your statement which will be submitted in full in the record. If you could briefly summarize, so Congressman Tauke and I might be able to ask you some questions based on your statements, which we have read and digested, that would be most appreciated.

Mrs. Allen, please? Thank you for being here.

STATEMENT OF ALETHA ALLEN

Mrs. **Allen**. Good morning, and I am glad to be here to represent the seniors.

I will just briefly say what happened. It was October, on a Friday morning, I had to go for immediate surgery for a gallbladder. I was released by Sunday morning, with pain and with nobody to go home to.

This was very hard for me, being a widow lady, to go up and down the stairs, fix my dinner, whatever had to be done. So, this is one thing I am complaining about.

I came out from the hospital, from the doctors, and I was not supposed to lift or work yet. I was to be alone, and a week later, I was to drive back to town to get the stitches out. So, naturally, the first thing I did was to call our senior citizen building to bring in my dinners, because I was unable to do that.

However, I feel that when we pay insurance, as patients, you should be able to stay longer and get better service. As a senior, I have found that my time was shorter and my time with doctors was shorter. These things I do not appreciate. So many of us, when we reach our golden years, think it is going to be a little easier for us, but instead I find it is a lot harder to get quality services, and the length of time from the doctors is not as good.

What do seniors have to look forward to now? Is it worth the money and the effort that we have these hospitals, when we cannot use them, or spend the length of time that we need? Do we really have to be worried what is going to happen tomorrow, or what tomorrow will bring, and feel insecure, in our country?

Some of these things are happening to us, and we are already helping other countries. What can we do to help our own seniors.

I think hospitals were not only built to bring life into the world, but to keep life in this world with loving, tender care.

Thank you.

Mr. **Schuette**. Mrs. Allen, thank you for your fine testimony. I appreciate your taking the time to be here today, and sharing with us the difficulty that you've had. I recognize that, unfortunately, too many times it affects us all. Thank you.

Mr. Corson, I do have a copy of your statement, which will be included in its entirety in our record. Would you care to briefly summarize, Mr. Corson, your thoughts and comments on the early discharge problem that we face here, today, in America?

STATEMENT OF FRED CORSON

Mr. **Corson**. Well, to begin with, I have a 48-year-old retarded boy home with me. I have my wife, 72 years old, and she has had four major strokes in the last 16 years. I have cared for her completely at home, and in fact, what I do, is operate a one-man nursing home on a 24-hour basis, and I am on call 24 hours a day.

We have a very great need for a medical care center or a hospital with a 24-hour service, in this area, where we can take people to get them stabilized. Otherwise, I have a 1½ to 2-hour trip to take her to a major hospital.

We need a team of a doctor and a nurse to visit the patients who are homebound. Many would be better off at home than in a hospital. My wife went in Clare Hospital for major abdominal surgery and she was released early. Approximately 5 days after surgery, I brought her home, and her stitches opened up completely on the incision. I took her to the local doctor here, that had sent her to Clare to begin with, and he recommended that I take her home and take care of it myself. They just put a large bandage on the incision, sent her home, and I was to keep it clean and keep her in bed, and it took about 10 days to heal.

We need the Federal Government to do something about the continued costs of drugs and medicine. It is increasing monthly, even on the generic prescriptions. My prescriptions, on a monthly basis out of my pocket, are about $140 to $160. My total, for the last 11 months is $1,600 or $1,700. The doctors have to prescribe a 30-day supply to me at a terrible cost. After you take these pills, a few of them, and find out you cannot take these, then these have to be thrown into the toilet and flushed away, which is quite expensive.

I thank you very much.

Mr. **Schuette**. Thank you, Mr. Corson, for your fine testimony.

Mrs. Wonsitler, would you care to proceed. Your statement, obviously, in its entirety, will be in the record. Could you please summarize your thoughts for us?

STATEMENT OF MARILYN WONSITLER

Ms. **Wonsitler**. Good morning. My father died 7 months ago, as a result of early release from the hospital. I feel that it was poor judgment on the part of the health care officials at that time. I have dealt with seniors for a little over 10 years, and I have heard of similar situations like this where people are not getting care and concern. They are released from the hospital without any thought given to the spouse, the family, or the situation in the home to what they are returning to. This is our greatest concern. Our home care program is good, but it does need to be better.

Mr. **Schuette**. Marilyn, thank you very much.

If I may begin, I will ask a few questions. And let me add here, as a point of information, given the limited time here today, if there are others of you in our audience that have any statements or comments that you would wish to insert in the official record, we will keep it open for a period of approximately 30 days. Before you go today, you may want to drop off any written comments you have, or within the next couple of weeks, send your comments to my Washington office.

Additionally, if you have individual problems or comments, I will be available after lunch. I will try to help any of you on an individual basis.

First, my question for Mr. York. I would like to comment on your suggestion that hospitals link early discharge senior patients with a case manager of a community based agency. I think this proposal has a great deal of merit and should be pursued, Mr. York.

Have you shared this proposal with the appropriate individuals, or health care providers? If so, would you share with me and our audience the responses you received. Mr. York, if you would.

Mr. YORK. I do have contact, on a regular basis, with social workers at the hospital. Of course, there is a strong concern we have, to work this out, in the sense of letting them know my feeling is that we should maintain close and direct contact, particularly with people being early released from the hospital. They have their hands full, and a lot of times, I think the social workers, as much as anyone else at the hospital, really have a difficult time making time to work out relaying information to me.

But I think it is so imperative, particularly for those are released and still require some care to provide health services in the home. The Case Management Program allows for linking these people with that care. Our case managers probably would have more time to work on individual cases with us as they are released with the social workers at the hospital.

Mr. SCHUETTE. Mr. York, an additional question. In light of the instances that you outlined of early discharges, in terms of assessing your responsibility in trying to solve a problem, or who is responsible for the early discharges, and how do you hold them accountable, Mr. York?

Mr. YORK. Well, under the prospective payment system, of course, the hospitals are being paid *x* amount of money, regardless of how long a person is there. You know, people are individuals, and individuals have different needs. It may take one person a lot less or a lot longer to recover from a particular injury or illness.

If anyone is accountable, it is, of course, the doctors and the hospital.

Mr. SCHUETTE. Thank you, Mr. York.

If I may, Mrs. Wonsitler, a question for you. Prior to the admission into the hospital, were you aware of the rights a Medicare beneficiary has, in terms of appealing an early discharge. A, were you aware of that, and B, could you share with me, in terms of what your experience has been, in terms of the rights of appeal?

Ms. WONSITLER. We were not informed of any of that before or after he was released. My mother, who is not a well person, had no idea that she had a Congressman or anywhere else to turn to for assistance. She assumed it was up to her and us kids to come home and help her when we could. So she had no idea that there was anything available to help her.

Mr. SCHUETTE. Mr. Corson, if I may direct the same question to you. Were you aware of your wife's right to appeal when she was discharged early, Mr. Corson?

Mr. CORSON. No, I was not. I was not aware of that. Afterwards, she should have gone back to the hospital and been kept there until her incision healed. But with me taking care of her at home, if the incision became infected, insofar as I concerned, they certainly have all of the blame.

Mr. SCHUETTE. Mrs. Allen, you shared with us your experience of your gallbladder operation. Were you aware of your rights, in terms of early discharge?

Mrs. ALLEN. No. I was not aware of that. I have insurance, but it was so flabbergasting to me when all these bills kept coming in. And when you are a widow with only one check coming in, it made it very difficult for me financially. Because before, my Blue Cross paid everything. And now it is not paying everything. That make things so complicated. I think the paperwork is terribly complicated for some of us seniors to understand.

Mr. SCHUETTE. Thank you, Mrs. Allen.

Congressman Tauke, do you have any questions for our fine panel?

Mr. TAUKE. Thank you, Mr. Chairman.

Mr. York, how far away are the hospitals from here? The nearest hospitals?

Mr. YORK. From Midland?

Mr. TAUKE. Yes. Well, from—let me just say people living in this congressional district, let us say. How far do they have to travel, in order to get to a hospital?

Mr. YORK. Well, actually, it depends greatly on—you are talking the rural elderly?

Mr. TAUKE. Yes.

Mr. YORK. I would say—I am from Midland, of course, but I would say 20 to 30 miles, would be——

Mr. TAUKE. Is there a hospital in this community?

Mr. YORK. I really do not know on that.

Mr. TAUKE. How far do we—how far do you have to travel——

VOICE. Thirty-two miles.

Mr. TAUKE. Thirty-two miles.

In your judgment, Mr. York, are there adequate nursing care services, home health services in the area?

Mr. YORK. It depends on if the person is able to afford to pay for that service. There are, of course, the private agencies which provide home health services, but that is something that is not covered under Medicare.

And for the rural, a lot of times, impoverished elderly, it is not always feasible.

Mr. TAUKE. So the service would be there if you could afford it. But since that service is not covered by Medicare, many senior citizens would be unable to obtain that service.

Mr. YORK. That is true.

Mr. TAUKE. Mrs. Allen, your story is a very disturbing one. In response to Congressman Schuette, you indicated that no one had informed you about your patient rights when you went to the hospital, or when you left the hospital, so that you had felt that you were not getting adequate care. You did not know that there was any place to appeal or to assert your rights. Did I understand that correctly?

Mrs. ALLEN. Yeah, because I mean, I thought when they said to go home, I should go home, even though I had to be by myself. And they knew I had to be alone.

Mr. **Tauke**. Now, when you went home, did you have any kind of care or service at home? Did you have any kind of home health care service?

Mrs. **Allen**. No. My son lives in Alpena. He was able to be down on the weekends. He went to church with me on Sunday, and he picked me up from the hospital and then he had to go to work. So I was left by myself.

Mr. **Tauke**. You indicated that you have been getting a lot of bills. Do you have a supplemental insurance policy to Medicare? Do you have Blue Cross, Blue Shield supplement?

Mrs. **Allen**. Yes. I have for years.

Mr. **Tauke**. If I may pry a little bit, what kinds of bills are you getting at this point, that have not been covered by either Medicare or the supplemental——

Mrs. **Allen**. These are partially covered. When I say they were not covered, they were partially covered.

Mr. **Tauke**. OK. Partially covered.

Mrs. **Allen**. But you take $100 here, and $100 there, and when you are on a fixed income, and it added up to me, as a widow lady.

Mr. **Tauke**. And these were hospital bills. Bills from the hospital, or from the——

Mrs. **Allen**. Yes, sir. Anesthesiologists, and like that. Their bills.

Mr **Tauke**. So you had bills from the physician and the anesthesiologist.

Mrs. **Allen**. And I had a small hospital bill, but not a large one——

Mr. **Tauke**. And a small hospital bill.

Thank you very much. Thank you, Mr. Chairman.

Mr. **Schuette**. Thank you, Congressman Tauke.

Ladies and gentlemen, I thank you for your fine testimony, and your cooperation throughout this morning. I thank you for your time. You have been helpful to me, helpful to Congressman Tauke. If I may, will our second group of panelists to come to the witness table.

Marilyn Duckworth, Albert Kleyps, Rosella Neumann, and Sue Schuler, please?

Thank you very much, panelists. Let us begin with Mr. Kleyps, if I may. Albert Kleyps is the director of the TRIO Council on Aging, which services Ogemaw, Roscommon, and Iosco Counties. And Mr. Kleyps, in the interest of time, I would request, if you would summarize your thoughts and comments for us here. And then we will hear from our other three fine panelists that have taken the time and effort to share their expertise and experiences, in various aspects of the aging community and senior citizen activities.

Mr. Kleyps, I am pleased and honored that you are here today. Would you please proceed, sir?

PANEL TWO: CONSISTING OF ALBERT KLEYPS, DIRECTOR, TRIO COUNCIL ON AGING; SUE SCHULER, DIRECTOR, REGION IX AREA AGENCY ON AGING; MARILYN DUCKWORTH, DIRECTOR, OSCODA COUNCIL ON AGING; AND ROSELLA NEUMANN, HEALTH ADVOCACY SERVICES COORDINATOR, AMERICAN ASSOCIATION OF RETIRED PERSONS

STATEMENT OF ALBERT KLEYPS

Mr. KLEYPS. Thank you, Mr. Schuette, Mr. Tauke, for being here this morning.

First of all, the pronunciation on the name is Albert Kleyps, a long A-sound.

Mr. SCHUETTE. Let me interrupt for a moment. I apologize. Your last name is almost as difficult as Schuette, and we all know what I get called on bad days, Mr. Kleyps.

Mr. KLEYPS. That is OK. I was 13 before I could pronounce it myself.

Mr. SCHUETTE. Please proceed, Mr. Kleyps.

Mr. KLEYPS. Good morning. I am the executive director of TRIO Council on Aging, Inc. We are pleased to participate in this public hearing on one of the most important issues facing the rural elderly to date, and that is home health care.

While the factors involved with the total delivery system of care to the homebound are complex and variable, I hope to emphasize some of the key aspects which affect the service agency, such as TRIO, in its ability to provide and recommend home health care to the older populations of our counties.

Northern Michigan is a beautiful area in which to live, work, play, and also retire. The elderly population in northern Michigan is currently the fastest growing segment of our society. In TRIO Council on Aging counties of Roscommon, Iosco, and Ogemaw, senior populations have escalated dramatically since 1970, alone.

For example, here in Roscommon County, the 60-plus population, according to the 1980 census data, was 4,649. This figure represents a 79.71-percent increase, over the previous census count of 1970. Similar growth patterns can be seen in other areas as well.

Ogemaw County senior population was 3,588 in 1980. A 40.98-percent jump in 10 years.

Iosco County experiences a growth of 51.88 percent, bringing its senior population to a total of 5,301 seniors.

If you equate the 60-plus population to the total number of people in our three county area, the percentages are as follows: Roscommon has a 28.39 percent senior population, Ogemaw County has a 21 percent population, and Isoco County has an 18.7-percent population. The statistics speak for themselves.

Obviously, the more elderly we have, the more health care services will be needed. While this, in itself, is not a problem, the increasing request for services, coupled with legislation designed to reduce Federal funding, has created one. At present, the demand for care is met. If the Gramm-Rudman-Hollings Act is allowed to continue on the present course, service providers will not be able to provide the present level of services, and will inevitably be forced to make proportionate reductions according to the budget cuts they experience.

Our service delivery also takes on new meaning as well. We are focusing more on the homebound seniors with our complex, multiple means. By its nature, this limits the number of clients which can be managed in a given period of time. Additional funding is necessary if case management systems are to support the increasing number of clients.

Should funding be restricted, waiting lists would come into play more and more. Nontraditional methods of health care for the elderly is growing in popularity. However, many people are still unaware of what options are available to them in the local areas.

Community service agencies from care providers are taking a more active role in providing such alternatives. Local interagency councils are taking initiatives in linking the program of health care services to the clients' needs and desires. Nontraditional care is playing an important role in reducing skyrocketing medical costs, as well. If it is to be successful in the future, however, legislative support, both politically and financially, is necessary.

Gramm-Rudman's arbitrary cuts, with no regard to merits of individual programs, is not a responsible method of budgeting. If cuts are necessary, a responsible budget should be made. Singling out domestic programs for spending reduction places unfair burdens on the elderly, the poor, and also the disabled. Such legislation appears to be an attempt to escape the tough job of making difficult choices involved in deficit reduction.

Lowering the deficit should be a priority for eliminating wasteful spending policies, doing away with tax loop-holes, and making conscientious decisions regarding budget cuts.

The rural elderly also face other unique situations, regarding health care, as well. Distances to hospitals may be as great as 65 miles in this area. Rising insurance costs are making health care unaffordable to many, and home health care is often available only to those who have insurance, or who are financially able to pay for it.

Compounding the overall crisis situation is the DRG system, which hospitals are forced to use. It is ridiculous, at best, to think that all patients can be lumped into one type of category, in a system such as this, and have it work on individual means.

Your consideration of these important issues is not only requested at this time, but urgently needed, and I urge you to support the concept of providing local health care and health agencies the financial resources and flexibility to use them. Work to achieve cost-efficient health care for the older person, not for the system which perpetuates itself through regulations and paperwork.

Thank you.

Mr. SCHUETTE. Mr. Kleyps, thank you for your fine testimony.

Mrs. Schuler. Sue Schuler is director of the Region IX Area Agency on Aging. Sue, I appreciate your coming here this morning, and Mrs. Schuler, would you care to summarize your statement? Certainly your complete statement will be included in our final report. If you could summarize for us, in the interest of time, and highlight some of the points and concerns, and help me and Congressman Tauke, I would greatly appreciate it.

STATEMENT OF SUE SCHULER

Ms. SCHULER. Thank you. It is my pleasure to be here today. The Region IX Area Agency on Aging is a 12-county rural planning and service area. It reaches from the bridge, everything east of 75, down through Roscommon and across Arenac County.

Primarily, the region is meant to serve areas where the senior population comprises 20.4 percent of the total population of the area, and far exceeds that of the State, in terms of the poverty level.

Low-cost transportation is a priority need, in order to access to essential services. It is the major means of transportation in the area. The dependency on the private automobile poses some additional problems for elderly persons. Purchase and maintenance of the automobile becomes increasingly difficult as income decreases. Physical limitations, and the growing complexity of modern driving conditions and declining health pose some other restrictions. National data show approximately 20 percent of persons 60-plus choose public transportation. In an area where public transportation is limited, alternatives and potential solutions must be explored.

To add to Al's comments, and to the gentleman who is the case manager from Midland, some of the people in the region must travel 1 hour and 45 minutes to a hospital. For instance, in Alpena, if you have a dialysis problem, if you need gynecology services, heart bypass, those kinds of things, you must travel to—the nearest hospital would be in Petoskey. That is 1 hour and 45 minutes away. That poses an extreme burden on people.

We have found that, through a 1980 fixed-needs assessment conducted by a regional area agency that 42 percent of our older persons travel at least 10 miles to see a doctor for illnesses not requiring hospitalization, and 8 percent travel 50 miles or more; 80.9 percent took prescription medication.

Over 10 percent state their prescriptions were from different doctors; 10.5 percent reported taking five or more prescriptions daily.

We conclude from that accessment that they have had to go to different physicians for different types of illnesses, and it makes it difficult in coordinating the kinds of medications they are taking, and clearly presents some health hazards to them.

Health resources are scarce in the region. With six counties designated as health manpower shortages, and medically underserved areas, what we are finding is that there is very little discharge planning going on, particularly for those people who are hospitalized in a county that is not the one in which they reside.

Currently, we have a small demonstration grant for case management services, that is somewhat limited in terms of the State, mainly that we cannot do the service in the entire region for a specific period of time. But we are finding that the evidence of need for that is regionwide.

We are attempting to do everything we can to make sure those services are not fragmented. But when you have discharge planning—or lack thereof, going on for residents of a county other than the one in which the hospital is located, if there is any kind of service coordination going on, it is minimal, at best.

People are being discharged quicker and quicker, and they are not being told they have options. They are under the impression that if they were allowed even to negotiate the date of going home, they are not going to be able to afford the additional days in the hospital because much of the cost is going to come out of their pocket. And they are terribly, terribly frustrated with trying to fill out forms they cannot understand. And I think those areas really need to be addressed.

[The prepared statement of Ms. Schuler follows:]

PREPARED STATEMENT OF SUE SCHULER, DIRECTOR, REGION IX AREA AGENCY ON AGING

Good Morning, my name is Sue Schuler. I am the Director of the Region IX Area Agency on Aging (AAA). the region is located in the northeast portion of the Lower Peninsula and is a twelve county rural planning and service area. The entire region is a medically underserved area with a senior population that comprises 20.4% of the total population of the area. 15.4% of the 60+ population is below the poverty level while 18.2% of those over 65 are below poverty level. This compares to 10.2% of the general population and 11.7% of the 65+ population for the State of Michigan. As you can tell from these statistics, both affordability and access to health care are of primary concern.

Low cost transportation is a priority need among the elderly for access to essential services. The private automobile is the major means of transportation in the region. With dependency on the private automobile comes additional problems for elderly persons. Purchase and maintenance of the automobile becomes increasingly difficult as income decreases. Physical limitations and the growing complexity of modern driving conditions and declining health impose physical and legal restrictions. National data shows approximately 20% of persons 60+ choose public transportation. In an area where public transit is limited, alternatives and potential solutions must be explored.

A primary factor contributing to the problem of access is the need for information about a complex and often fragmented service delivery network. Seniors are often unable to get services, not because the service is unabilable, but because they don't know where to look or whom to approach. Such barriers may prohibit many elderly persons from obtaining correct information and, thus, receiving adequate and appropriate services.

Health resources are scarce in Region IX with six counties (Alcona, Alpena, Arenac, Montmorency, Oscoda and part of Roscommon) designated as Health Manpower Shortage and Medically Underserved Areas. There are critical barriers facing the elderly resident when seeking the appropriate levels of health care. Lack of a system to effectively manage and coordinate alternatives to institutionalization contribute to the utilization of the most expensive forms of care such as nursing homes and acute care hospitals. The need to explore less expensive forms of care that promote independent living, where possible, is essential.

There are fifteen nursing homes in the region - three are affiliated with national corporations. There are a total of 1,188 beds. A survey of these nursing homes, conducted in April 1984, showed that most homes had waiting lists and bed usage rates were in excess of 90% average. There are five hospitals in the Region with extended care facilities. Four of the five have waiting lists. The long-term care plans of both the State Department of Public Health and the Region 7 HSA attest to a need for additional Home for Aged facilities throughout the PSA.

Formal home care in Northeast Michigan, somewhat expanded in the past two years, is provided through several agencies with some overlap in service areas. Local Health Departments provide home health services but due to their own budget limitations are able to respond only to a fraction of the need. The demise of county general revenue sharing funds may further curtail the Health Department's capabilities to provide services. Michigan Home Health, a certified Home Health Agency, based in Northwest Michigan, provides services to nine of the twelve counties; Respi-Care of Gaylord serves four of the twelve; Vital Care serves two of twelve; Huron Shores Health Care serves two of twelve; and Mercy Hospital of Grayling is just in the process of starting a Home Health subsidiary. At least, one private, individually operated Home Health venture is also operating but is non-certified and provides services based on a private pay basis only. Except for the one known individual venture, all agencies are third party certified and provide skilled level home health care as their primary focus.

The AAA funded in-home care services as well as family, friends and volunteers, provide the greatest amount of basic and custodial care services. Subcontractor reports indicate that numbers of clients needing services has increased considerably with necessary prioritizing of available service hours based on degree of need.

H.S.A. 7 has addressed the home care situation through a current, ultra-high priority goal:

> "Both skilled and basic home health services shall be available and accessible to all residents in H.S.A. 7."

Although a range of health and social services exist in the twelve county area served by the Area Agency on Aging, they are fragmented and have minimal capacity to absorb the problems of a rapidly expanding elderly population. The catchement area specifically lacks: primary care physicians, linkages between the health care system and the aging network and a stable system for linking and coordinating services in a continuum of care for the elderly. As a direct result, many elderly are not able to seek medical attention until they are severely ill and require placement in an acute care hospital or nursing home. H.S.A.-7 again acknowledges the need for care management and coordination by stating in their plan's Health Care Section rational: "Case Management services are an integral part of the provision of both basic and skilled home care. That is, home care includes the coordination of all health and human servics a client needs or receives."

The 1986 needs assessment conducted by Region IX reiterates the sensitivity of the senior population to the demand for and importance of in-home care. Of 23 categorical services listed, Home Delivered Meals received the highest number of notations for need (539 of 680), with Homemaker/Chore receiving the second highest (513 of 680). Categorically, the In-Home care section, in general, was the predominant area for indication of need.

In the Michigan Survey of Needs, 20% of rural older persons listed "Health" as a problem area. National figures indicate that 80% of individuals 65 years of age and older have one or more chronic conditions, treatment for which accounts for 30% of health care expenditures.

Self reports, in a 1980-81 survey, reveal some of the problems Region IX citizens face in health related areas:

- 42% of older persons traveled at least ten miles to see a doctor for illnesses not requiring hospitalization - 8% traveled fifty miles or more

- 80.9% took prescription medication

- over 10% state their prescriptions were from different doctors

- 10.5% reported taking five or more prescription medications daily

The ratio of health care professions to the population is significantly lower in Northeast Michigan than the State as a whole.

Utilizing a sampling of Physicians, Dentists, and Registered Nurses, the following ratio comparison is shown:

	Region IX	Michigan
Physicians - one (1) to	1,695	663
R.N's - one (1) to	371	223
D.D.S's - one (1) to	2,661	1,941[16]

It can be seen from the above that the most crucial medical shortage is in Physicians and R.N's. Fewer health care professionals exist to service a diverse population - who must drive considerable distances for this care. The services of "specialists" would require traveling an even greater distance.

Meeting the health service needs of the rural population in general is an on-going concern; the needs of the rural elderly is a major component of this problem.

The information contained in this presentation is a part of the determination of need in the area plan for the region as developed by the agency's Services Manager Mary Ann Christianson. There are a number of other areas of need indicated in the plan and I would be happy to furnish this committee with any data which would help in its deliberations. I would like to thank the committee for this opportunity to offer testimony.

Mr. SCHUETTE. Thank you very much, Mrs. Schuler, for your eloquent testimony. We are grateful for your presence here.

Our next witness is Marilyn Duckworth. And Marilyn is the director for the Oscoda County Council on Aging. And Marilyn, I appreciate your time, and for our stenographer, make sure, if you would, that that other microphone is close by.

Marilyn, if you would, could you summarize your thoughts and concerns for us in issues that impact you on a county basis, dealing with rural health care concerns, retired citizens, transportation, what have you. If you would share that with us, I would be most grateful, as would Congressman Tauke.

STATEMENT OF MARILYN DUCKWORTH

Mrs. DUCKWORTH. Thank you.

I am not a very good artist, and I am not good with the charts, or I would have brought you a picture. Now you have met the bucket lady.

I guess what I am trying to say is that if you and I understand each other's level, it makes it a lot easier. You work hard at your level to make sure that money gets to us. So let us assume that the large bucket is full of money from the Department of Health and Human Services. That is great and we appreciate any money from the Federal Government.

When you are providing home-delivered meals, hot meals in senior centers, and in-home services, you need the money. You fellows are the ones that provided it for us.

And so where does the money go? It trickles down and gets administered. Then what happens? It goes to a regional level. And again, it is administered, that is what you call it, right?

Then it goes to the State of Michigan. And again, it gets administered. Then it goes to the area agencies. And again, it gets administered. The money finally reaches one of the small counties in the State of Michigan and finally, we provide the seniors some services.

But I must remind you, again, it gets administered. But I would challenge any administrator before me to live with a salary comparable to those in the field.

Do not let Gramm-Rudman reduce our funding. Who knows where we may be next. So, with that in mind, let us talk about all these services that have so little money to provide.

In our county, we have about $36,539 of Federal funds. We receive an additional $13,300 from the USDA that we use to provide home-delivered meals and congregate meals. The rest of our funding comes from the County of Oscoda, up to a maximum of $30,000. The clients themselves provide an additional $20,000. The State kicks in about $27,300.

So, if Gramm-Rudman gets us with a 24-percent cut, I hope you can understand how this is all going to affect us, because these services have to be paid for. And in your dilemma to make those cuts, I request that you consider not adding mandates and strings to the money we get. We just cannot deal with more mandates. And as each level of administrators administrate, they add their own mandates, their own rules of eligibility, all for the good of clients. But none of them provide the services.

Mr. Schuette, I live in a real world with real clients, where the wind howls, and we work with a whole person, OK? I live in an area where the closest hospital is 50 miles away. That is not the best, but it is the closest. All the money in the world cannot make a person well, happy, and hopeful. Sometimes it takes being at home, someone to listen, and even a smile. That is partly what we do.

And I have to state for you some recent situations that we have run into in Oscoda County.

Ben, a 90-year-old gentleman, got along famously at the home. You knew he was home, because you could hear him playing the piano as you came in. This winter, he was up, he shoveled the snow off his roof. He did not ask anybody for anything.

One day, he was going out after his mail, fell, and broke his arm. All of the independence in the world was taken away from that man. He could not even fix a pot of coffee.

Well, a neighbor took him to the hospital, and his neighbors took care of him. The senior center delivered him his meals. We could only be in there to deliver meals. We deliver about between 25, 35 meals in 93 miles. We have to get on our way. That person can only stay for a couple of minutes. They have to get going.

So, this man started to deteriorate. His closest family were in Ohio and North Carolina. Between the neighbor and I, we decided that he had to have some help. He could not be left alone to continue to deteriorate. So, we called his family, and naturally he had to go live with them.

We hope that he will heal, and can come back. That is our only hope. If we had let him deteriorate too much, we know he will not come back. It just is impossible.

Another one was sent home from the hospital with a broken leg. He went into the senior apartment. We have a real nice senior apartment in Fairview. But the rules in a senior apartment say that you have to be able to take care of yourself. You cannot be in an apartment and have somebody living with you. He did not have a choice because he could not afford his own apartment or a nursing home. So he continued to deteriorate to a point in time where the apartment director called and said, Marilyn, we have got to do something. And again, we had to call on the family, to take care of him. It was a blow to him. He had been independent.

It is not just broken bones that get you. It is a lot of things.

Just this week we have had a call from a person who receives Meals on Wheels in our county. The husband reported that his wife was taking pills. She was just running through the house taking pills, trying to find anything she could get. We called the health protective person, but he was not available. We called the public health nurse, she was out on call. So we made arrangements to get her to a doctor.

Lo and behold, my staff person was told that there were 46 people waiting to see the doctor that day. This was at 12:30 in the afternoon. Now, realistically, 46 people—I do not know what kind of doctors you have, but we are medically underserved.

And a public health nurse cannot be everywhere. We have one nurse working 565 square miles. So the staff took her to the doctor, and we got her taken care of. We called mental health and the soonest we could get any help from mental health for her was the next day in West Branch, which was 40 miles away from where she lived, or the next week in Mio.

Well, you know, that is not realistic. And you do not have to be old to have a problem. I fell and broke my leg last July. I was taken into the hospital, my leg was broken in four places. They set it, put it in a cast, promptly put me in a wheelchair and delivered me to the back door of the hospital. They said I am sorry, you have not gone into shock, but you will, because of the kind of break you have. Your body cannot stand it, but until you do go into shock, you must go home.

So, they loaded me in the car, and they took me 21 miles home. And I got just about into the house, and wham. So, they loaded me back up into the car, took me back to the hospital, and I spent 36 hours in the hospital. Now, that is ridiculous. But it saved hospital costs, and that is what they were trying to do—save hospital costs.

So, there we go. We are saving hospital costs, but what else? You know, before DRG's came along, elders could stay in hospitals just a little longer. And was it really a waste? It is expensive, I will grant you, and I know we have to cut costs, but there was a service provided there. Someone was taking care of these people. They were not just thrown out. Back then, we talked about people falling through the cracks. Mr. Schuette, they are falling through gaping holes now.

If we do not have the money, we do not stay in the hospital. New modern techniques saved an elderly woman, but every 3 days, she has to negotiate to stay in the hospital. The hospital in Grayling had to hire the people from Traverse City to come over and take care of her, even in the hospital. And every day the husband said, I cannot go through this any more. Every 3 days we talk about sending her home, and he is scared to death. He could not take her. She has a shunt in her, and it is new, even in the medical field.

The nursing homes cannot take her. But, her 90 days in the hospital are almost up. Now, what is she going to do? The husband is scared to death, and she has got to go home. Who is going to provide those services?

Well, we can cite a million things, and it is going to keep happening. But we have to, somehow or another, say, whoa, stand back, take a look.

We have got people under so many stresses that there are all kinds——

Mr. SCHUETTE. Mrs. Duckworth, could I ask you to summarize, because I want to ask a number of questions. I have many for you and other panelists, as does Congressman Tauke. In addition, I want to ensure that Mrs. Neumann gets an opportunity to speak.

Could I ask you to do that in a summary fashion, please?

Mrs. DUCKWORTH. Just about there. When we save on hospital costs, do we really look at what the real costs are? We have to provide some supportive services and referral services. The senior centers cannot do that alone. All of us have to work together.

Please, when you send the money down, do not send it with so many strings attached that we cannot even help our people. We have a board of directors who is working very hard to try to help our people. They continue agonizing over funds, with rules that do not fit, or even make sense. Let us help our people, and thank you, again, for allowing me to talk to you.

Mr. SCHUETTE. Mrs. Duckworth, I appreciate your time, and your testimony, which is disturbing. It causes concern, but it is important that it be shared, and I thank you.

Mrs. Rosella Neumann is a Governor-appointed member of the Michigan Commission on Aging. In addition, she is the health advocacy services coordinator for the AARP, and has been a leader in senior activities in the State for some time.

Mrs. Neumann, I thank you for being here. If you would please summarize your testimony for us, and share with us the experience and knowledge you have obtained through your longstanding involvement in the senior services.

STATEMENT OF ROSELLA NEUMANN

Mrs. NEUMANN. Thank you, Mr. Schuette, Mr. Tauke. Thank you for having me, and giving me the time to share some of the things with you, and my fellow senior citizens.

You will be getting a copy from the office of services to the aging, and you will be getting a copy from the National AARP. But since they represent different kind of views than our rural problems present, I think that maybe I will just hand this in after I have finished, and I hope that you have a good typist, because my typewriter does not spell worth a darn.

Mr. SCHUETTE. Mrs. Neumann, I will do my very best to hunt and peck for you, and we will get that typed up. I am just pleased you are here.

Mrs. NEUMANN. Well, it is not that we think our problems are more or less important than any other seniors in other sections of Michigan, nor do we think that we are more or less important than other seniors. But we might have some incidental happenings in our rural areas that do not show up in the other parts of the State of Michigan.

I know you have been deluged with statistics and numbers, as we all have. And you must find it very difficult to put names and faces on these numbers, so that they vaguely resemble human beings. We live in a world of numbers and acronyms, and that alone adds to all our problems.

I have the advantage of being involved with programs for the aging in Michigan, and I have the distinct pleasure of growing older with the people that I have served. And so, having directed a senior center for 15 years, I know some of the problems.

The fact that we are all aging, you included, just 1 day at a time. We see a tremendous change in the picture of aging. And I, and all the senior citizens in this room, are going to be ready to take the blame for some of your legislative headaches. We have lived a wonderful span of life. We have lived from lamp lights and horse and buggies, to flying out into outer space, and a completely computerized world. We have lived on simple foods that had to be preserved or dried, to the supermarkets, with a gorgeous, year-round array of fruits and vegetables, that have led us to longer lives.

We have gone from the family doctor who made house calls with very simple remedies, to computerized clinics and organ replacement that boggles your mind. And it is easy to think that some day you will walk around with your heartbeat in a suitcase. It is a fantastic picture. And we senior citizens have made it ourselves.

We do not die from broken hips and complications. In 3 days, they have you up on your feet and walking, and all pinned together, and you live to contract something like diabetes, or hypertension, or our recent, newest dread enemy, Alzheimer's disease. All these kinds of things that we have really lived to see.

We do not even easily succumb to a heart attack any more. You have bypass surgery, and you go on to develop hypertension, and all of that that they have to give you when you go through such serious surgery. We did not look forward to that before, because I remember as a little girl, that one of my aunts was operated on on a kitchen table covered with a light sheet, and the instruments were boiled in water on a cookstove. And 3 days later, of course, she died, because of the lack of medical care. And it was then that I decided that if ever I could do anything for people, I would. And this is what led me into the nursing field. And this is where I have picked up a lot of these problems.

We senior citizens have been a part of this tremendous process. If not directly, we have created the geniuses that did it. It is our grandchildren and our great-grandchildren who are entering this fantastic world, and trying to solve our problems that we have not.

In our eagerness to live longer, we have become four- and five-generation families. I could tell you about 12 couples I know over the age of 60, who are taking care of older parents. One couple, both over 65, are responsible for four parents, 85 years of age and older. They are not financially, physically, or emotionally capable of taking on that responsibility without outside concerns and assistance.

With our primarily agricultural communities, and those statistics that we talked about, we have a greater number of older women who have never entered the work force, never trained for jobs, or perhaps worked at poorly paid jobs, with no retirement planning. And they are now in the poverty squeeze. Our small industries did not provide for widows with pension plans, and so they diminish the income of the older woman alone.

Life seemed so simple when I was a kid. There was not a house without a grandfather, a grandmother, an aunt, or an uncle. But now, in our transient world, with a lot of our young people leaving the rural areas to find better jobs, or following military careers, we lose the family picture. And it is a loss of the family structure that I feel has a lot to bear on the problems of the older people in the rural area.

Now, with our transient population, and our social acceptance of divorce and remarriage, the grandparents and great-grandparents are often lost in the shuffle. Many are even denied the visiting privileges. They do not even get to know their grandchildren. And to add to that, our Department of Education pointed out that 15 percent of our senior citizens are illiterate. I believe that the percentage is higher in our mainly rural area. In my work with AARP, we train Medicare assistance volunteers. And that means the Medicare and supplementary insurances are not understood by our older people. It leaves them in a void.

Case management is the sort of program recently funded by the State of Michigan Office of Services for the Aging. It is still in its infancy here in this area, but it is designed for the purpose of keeping persons in their own home, independent for as long as possible.

I would like to share a couple of excerpts from case histories of case management.

Mrs. S. is 81 years old, and has not been out of her apartment for a year. She shared that apartment with a 62-year-old daughter, who did housework for other people on a part-time basis. Mrs. S. had difficulty walking, and first asked for help in getting a wheelchair. She was obese from lack of exercise and constant eating. The daughter asked for assistance in moving her mother and herself to a senior citizens housing, where her name had been on the waiting list for over 2 years. In the moving process, it was discovered that it was impractical to put shoes on the client, because her toenails were grown over her toes and under her feet.

A nurse from the health department was called in, referred her to an orthopedist. Provided with transportation and an escort assistant, she was taken to be fitted with shoes, the first she had worn in 4 years. Now, walking with a walker, and getting assistance with nutrition programs to control her weight.

Mrs. G is a double-amputee, in a wheelchair, and requesting assistance in getting groceries. She lives alone, and is visited on a regular basis by home health care and her social services caseworker. She is able to cook for herself. She lives a quarter of a mile off the main road, and one volunteer had difficulty reaching her several times, because her door froze shut during the winter storms. A neighbor keeps her road plowed out. A homemaker does her shopping for her. A senior companion spends 10 hours a week with her. Volunteers get her to the doctor for regular visits, and several of her church group call on her.

Mr. T is 71 years old and has Parkinson's disease. He is confined to a wheelchair, he lives alone in an apartment. He has a cleaning lady going in three times weekly. She cleans the apartment, helps him with his bath, and washes his hair. He receives home-delivered meals, has a senior companion, spending 10 hours a week with him. He is called upon by his social service worker, a visiting nurse, and a case management worker every other week.

Do these sound like success stories? You bet it does. But for every one we reach, there's hundreds out there that we cannot. Because needs—not because the needs are not recognized, but there is not enough of us, and there is not enough money to go around. I would hope that the powers that be, you legislators, will be the people who will be our ultimate answer in this dilemma that we have created for ourselves. We hope that you will consider carefully what we believe will be a way to economically and effectively serve our purpose.

We need large-scale development of living arrangements, that offer maximum independence, with necessary services to elderly residents. I believe the lack of supervised living facilities represents a great gap in our service system for the elderly. Where we talk about long-term care, we immediately think of nursing homes. And I think there are gaps in our long-term process that have to be filled, and this is one of them.

In the appropriate protected living quarters, most elderly people can manage, with some help supplied as needed. In group living, they assist one another. It saves hundreds of miles in transportation for workers, if the clients are in group settings.

We need expansion of meal and nutrition programs to keep up with our ever-growing population of older people. Good nutrition should be recognized as the key to good health, and therefore generate support for congregate meals, home delivered meals, and nutrition education. We must maintain this as a corrective and preventive measure.

We need adequate transportation. If older people are to participate in the life of their community, as both consumers and contributors after they stop driving, they can only do so by public transportation. This expensive service—and we do know that it is expensive—must be supported by public funding to guard against isolating and neglecting the elderly segment of our society. It also provides a great problem in getting the services to our clients, since we seem to have the proverbial Paul Bunyan miles here in northern Michigan.

We need long-term care health insurance. As the elderly population grows, so does the number of people requiring long-term care. We need prepayment insurance plans, with broad coverage for this costly care. Our private and public health insurance systems are just waking up to this need, and they need a legislative shove. We are grateful that only a small percent—I believe 5 percent of our total population of seniors are in need of nursing home care. We feel that some do not need to be in nursing homes. That home care, and case management is an alternative.

We need support for the Federal legislation on Alzheimer's disease, that will amend the Older Americans Act to include programs for home health care, day-care training, and tax breaks for the senior citizens caring for older Alzheimer's disease victims. We need training for the caregivers, to protect them from the stress of caring for the frail elderly, like the 12 couples that I mentioned that were over 65.

And most important, we need continued support for our senior citizen centers. There lies the greatest treasury of all-human resources. People. People with a lifetime of experience ready to share with one another the services for the demands of daily living, catering to the needs of a 40-year span of life—from 55 to whatever. To many people the center is a home away from home. The information and referral, the consumer education, the health services, the recreation, the case management, the opportunity for voluntarism that keeps them in the stream of community living, and interested in what goes on about them. Living loses its flavor, unless you have something to live for. And as one of my favorite clients used to say, "You's guys give me something to get up in the morning for."

Our needs are not that elaborate. You will find in the long run, they can be met economically. It is a case of people helping people, with physical limitations, our natural components of aging, just ordinary acts of daily living soon become major needs. We are not talking about investments in buildings. We are talking about investments in human beings—an investment that, in the long-range planning, our health care in northern Michigan, will pay off well.

I am reminded of a phrase written by George Washington Carver. "How far you go in life depends on your being tender with the young, compassionate with the aged, sympathetic with the striving, tolerant of the weak and strong, because some day in your life, you will have been all of these."

Thank you.

Mr. **Schuette**. Mrs. Neumann, thank you for your excellent testimony and your comments. You have done an extremely—just a wonderful job, and I thank you.

If I may, I would like to begin with some questions. We heard from our panel of beneficiaries, who expressed a concern about early discharge. And I am sure you heard their concern, and their instances of being discharged early from a hospital.

As activists in the senior community, could you—each of you four share, briefly, what type of communication you have received from health care providers on the early discharge? I would like to follow up on Mr. York's comments. When the hospital chooses to release a patient, how can we better inform the patient of, A, the appeal rights, and then B, what type of communication is there between your agencies and the hospital? For example, when an individual in a rural area is discharged from the hospital, do we monitor and communicate, check and assess, the patient?

Mrs. Neumann, would you please begin.

Mrs. **Neumann**. Yes. The AARP Health Advocacy Services has put out a program that has really caught on. It is called "Knowing Your Rights." And if you people will just give me your name and address, I will see that you get a copy of the book. And when you read it, please hand it out to a friend, or bring it to your groups. And we do have a slide presentation on that same program. And we do have AARP members that are available to put on this program in your centers, or whatever. But if you would, as an individual, would like some of that material, please do write your name and address, and I will see that you get it.

And I would like to caution you all—get it in writing, and get it dated, and get the time on it, because you have a 2-day grace, after they tell you that you can leave—you have a 2-day grace to appeal. But be sure that you have anything that the hospital lowers the boom on you, in writing.

Mr. **Schuette**. Regarding the communication you have in Oscoda County, when a patient is discharged, can you monitor their movements and health following discharged from the hospital?

Mrs. **Duckworth**. Well, we keep a good rapport with the discharge planners in the hospitals within our region. The only problem we run into there is the different kinds of paperwork and the range of information. DSS has their own requirements. Public health has their own, of course, we have our own. And we need to develop a way that some of that information be shared. Because you can assess a person to death, and that is the weakest area in this problem. We need more communication between agencies.

Mr. **Schuette**. Mrs. Schuler, if you may?

Mrs. SCHULER. I am sorry to tell you that we have no communication with health providers, including hospitals, as to the change, and what they might do in terms of discharging elderly patients.

However, we furnish, in lieu of not having those from the health providers, we furnish them with some information relative to the senior centers in each county, and the services that they provided. However, they are a planning and coordinating body, so perhaps we are overlooked.

Mr. SCHUETTE. If I can follow up, there, Mrs. Schuler, has communication gotten better? You say originally there was no communication at all.

Mrs. SCHULER. I cannot say that it has, but in a sense, we are not the agency that would be working directly—we are not the bottom level, in terms of working right in the home of the client. We are the passthrough for that Federal and State funding, and are a planning body.

I will say that for those patients who are traveling outside our region for medical health, that some of that coordinating efforts from the hospital have increased as a result of meeting with them and giving them some senior service directories.

Mr. SCHUETTE. Thank you, Mrs. Schuler. Mr. Kleyps, would you share with Congressman Tauke and me how the TRIO Council on Aging works with local hospitals when a patient is discharged, in terms of monitoring movements, health, and assistance, if you would please, Mr. Kleyps?

Mr. KLEYPS. Yes. I think we are a little bit more fortunate in our area than in most areas, because we have a couple of really good discharge plans. The people and the hospitals we are working with, Tollfree Hospital, out at St. Joe's Hospital, and also with the Grayling Mercy Hospital, communicate with us.

Regarding the informing situation, mainly we get involved in communication with the discharge planner. And again, it is on an individual as-needed basis. We often get phone calls from the discharge planner to our offices in West Branch, asking to talk to our caseworkers about a particular client who is leaving the hospital today, or tomorrow, or whenever. And fortunately, we do get advanced notice of some of the real critical clients that are leaving the hospital.

Most of this, to reiterate, is done informally, although we do have interagency council meetings that we meet once per month. The problem with that type of setup is that, oftentimes, not all of the agencies are allowed by their schedules to participate in the meetings.

Mr. SCHUETTE. I have one other group question. It seems to be in this day and age we should have a high priority—or probably the highest priority should be on providing the highest quality care to the recipient. And certainly health care to the rural elderly in the real remote areas, more inaccessible, puts a premium on delivery. Inaccessibility puts a premium on the quality of the care because of the distances involved. There is a balance, however, between the highest quality health care and a reasonable cost to individuals. I am a little—I am more than a little concerned that the prospective payment system is impacting the quality of care with this effort to reduce costs. And I am very concerned about the health of the recipient in the health care system today.

If you all would, from your various perspectives, share with us whether the new DRG prospective payment system is impacting or causing damage to our health care delivery system and the quality of the health care today in rural Michigan. Mr. Kleyps, if we could start with you?

Mr. KLEYPS. It has a very negative impact on the service—delivery system that we now have. I do not believe the doctors like it, I do not believe the hospital administrators like it. Our case managers do not like it. I do not like it. The patients do not like it. Apparently the only ones who really like it are the people from Harvard who thought of the idea, who are sitting back and collecting their happy paychecks for doing it.

Mr. SCHUETTE. Thank you, Mr. Kleyps. Mrs. Schuler, please?

Mrs. SCHULER. I find it interesting to know that some of the hospitals, urban in nature, are making money, despite the DRG regulation, while the DRG regulations do not take into account that it takes *x* number of dollars to keep a rural hospital open, regardless of their payment schedule. They do not take into account that their costs are far beneath those for rural hospitals.

I guess I would urge the committee to address the cost containment issue in health care. But if we are going to be discharging senior citizens earlier, as a manner of containing costs, then would you please pump out the budgets for those vital services that they need. Sometimes it is only a week that they need a little bit of help, so that it makes a difference whether they are going to end up being readmitted, and in some cases whether they might even die. And at the time of trying to contain health care costs, we are also cutting back on those vital supportive services, and I think we are putting all of our seniors who have any kind of health problems in a state of crisis.

Mr. SCHUETTE. Thank you, Mrs. Schuler. Mrs. Duckworth, if you could answer that same question regarding the competing goals of providing the highest quality of health care at reasonable costs. I am particularly for our senior citizens, because they use health care services at the highest rate in our population today.

Could you give me your brief comments on the new DRG prospective payment system and whether it is whittling away the high quality health care that we want to provide to the senior citizens today in America.

Mrs. DUCKWORTH. When you look at DRG's, you also have to look at insurance. And whether they can afford insurance. I have been told by many seniors that Social Security should be made a third of their income, and if they are dealing with social security being their entire income, and they cannot afford insurance, Medicare should provide more coverage. With DRG's, these people are caught in such a dilemma that it impacts their health and emotional stability. They cannot deal with that. There is nothing out there that is being provided for them for every time they get a drug, they do not even know the doctor's name. It was some guy walking down the street, they think.

Mr. SCHUETTE. Thank you. Mrs. Neumann.

Mrs. NEUMANN. I come from a county where the hospital has rural designation, and yet serves four counties. The furthest person from it, I believe, would be about 70 miles——

Mr. SCHUETTE. If I may interrupt, Mrs. Neumann, this is the hospital in Alpena?

Mrs. NEUMANN. Yes. Alpena County. And the third month after the DRG's became effective, they laid off 33 people in 1 month. And that is a traumatic happening in a community the size of ours. They blamed it on DRG's, and they started to claim that a rift—an intergenerational rift—because youngsters did not understand the dilemma senior citizens were faced with.

But when Medicare first came into being, it was a carte blanche kind of thing. You went into the hospital, you stayed there as long as your hospital said you did, and the bill was met. And so, it really was the use of Medicare that led to this kind of thing.

And now, we want to remember that it is not the hospital, really, that makes the decision on whether that person goes home or not. But they do put the pressure on the doctors to get the people out as practicably as they can.

And another problem that has arisen is outpatient surgery. It used to be when you had an operation, you were in bed for 10 days, could not even move your head. Two weeks ago, I knew an 82-year-old women who went and had a cataract operation on her left eye, and at 4 that afternoon, she drove her car home. Now, I believe this is really unsafe—not only for her own safety, but the safety of the people that might have been involved in an accident that she caused. And believe me, I told the doctor so. Whether it is rural or urban, these kinds of things should never happen.

Then we, in a letter-writing campaign, got our hospital renamed as a referral hospital, because it took care of so many counties. Now my administrator tells me that within the last 3 days, that we are being redesignated to a rural hospital. And so our income will fall again. But I want to say that it costs more to keep a hospital running in a rural area, because you have to pay for so many more miles of delivery systems which we cannot purchase like the great big hospitals can and we cannot do those kinds of things.

And so, not only are we lacking personnel, but we are lacking the equipment to keep a hospital going as a rural designation. And we will be taking a 58-percent cut in what we are getting now for patients.

Mr. SCHUETTE. Mrs. Neumann, did you say 58 percent?

Mrs. NEUMANN. We will be taking a 58-percent cut.

Mr. SCHUETTE. Mrs. Neumann, your comments on rural hospitals I think, again, are indicative of a problem with the PPS system——

Mrs. NEUMANN. Definitely.

Mr. SCHUETTE. And the theory of it is that you will balance off losers with gains. But in a rural hospital you do fewer of the type of surgical operations which would inure to the benefit of the hospital. Hence, that theoretical picture does not work out.

Mrs. NEUMANN. One gentleman had a supplementary insurance that was to pick up the difference, and it would not pay, because he did not stay in the hospital overnight. So he had to foot that bill, too.

Mr. SCHUETTE. Mrs. Neumann, thank you for your statements.

Congressman Tauke, do you have some questions for our panelists?

Mr. TAUKE. Thank you very much, Mr. Chairman.

I hardly know where to begin, but we are running late, so let me just touch on a few factual questions. First, for the record, Mrs. Duckworth, in Oscoda County, how many doctors do you have?

Mrs. DUCKWORTH. We have two full time, and about three part time.

Mr. TAUKE. What is the population of the county?

Mrs. DUCKWORTH. About 6,800.

Mr. TAUKE. When you had the broken leg which you referred to earlier, that problem which is hard to believe, but I do believe you——

Mrs. DUCKWORTH. I did——

Mr. TAUKE. I do not mean from that standpoint. I mean what happened. What hospital was that?

Mrs. DUCKWORTH. It was downstate at—it happened on a neat weekend, when all the orthopedic surgeons were on strike in the Flint area. Thank goodness they took me to Lutheran General.

Mr. TAUKE. But the—that hospital—was it the hospital or the doctor, or who told you that you should go home and then, of course you had to turn around and come back.

Mrs. DUCKWORTH. The doctor.

Mr. TAUKE. The doctor told you that. Did anyone at that time talk to you about whether you should go home, or when you—did anybody suggest you might be able to stay if you want, or did you try to stay?

Mrs. DUCKWORTH. Those decisions were all made for me. My family said that they did not want to take me home, because they knew I would be right back, but they said no. I had to go into shock. Then they would keep me.

Mr. TAUKE. Mrs. Schuler, you are right, there are a lot of hospitals making money under the DRG system, or prospective payment system. Last week, in testimony before the Senate Finance Committee, we learned that about 80 percent of the hospitals, apparently, are doing better than they did before under the old system. And the ones that are not are relatively few and far between. But there are some characteristics that are common among those who are not making it.

They are either inner-city, or they are rural. And they have a high percentage of Medicare patients. And it sounds to me like you have some of those hospitals in this area. But you talked about transportation needs.

In my district in Iowa, I do not think there is anyplace that is more than a half hour from a hospital. Trips of 1 hour and 45 minutes to get to a hospital, you are suggesting from some parts of the area you serve.

Mrs. SCHULER. For certain services.

Mr. TAUKE. For certain services.

Mrs. SCHULER. Some of our counties have no hospitals in the county. But for certain services—you see, the health system agencies who help plan to constrain the health care costs, so there are certain things that your hospital cannot have.

For instance, the equipment for dialysis, or the equipment needed so you can do bypass surgery. Or maybe putting in the physicians, even if you have the equipment. But when you need those kinds of services, and if you live in Alpena County, you are going to need to travel 1 hour, 45 minutes to Petoskey, to get that kind of service.

Mr. TAUKE. Is there any kind of transportation available for the senior citizen who does not drive?

Mrs. SCHULER. We have some volunteers who will drive. We do have some—they are called—they are some of the Department of Transportation's 16-B2 vans—I do not know if you are familiar with the terminology. And what we try to do is get all of our seniors to schedule their appointments for the same day from a given county, so we can get permission to take that bus for an essential health care service out of the county.

Mr. TAUKE. And for people that are living in these counties where there are not hospitals within a reasonable distance, obviously this local home health service, the nursing service is doubly important. And then, in addition, transportation services are critical.

Mrs. SCHULER. Absolutely.

Mr. TAUKE. I guess, Mrs. Schuler, I gather that you are one of those buckets that Mrs. Duckworth——

Mrs. SCHULER. Yes. Mrs. Duckworth's buckets are not exactly scientific, but you have to imagine there are 12 of those buckets——

Mr. TAUKE. We will not try and sort that out. I think we got the point——

Mrs. SCHULER. The point is well made.

Mr. TAUKE. Yes. Mr. Kleyps, first of all, I just wanted to observe, you talked about the danger of Gramm-Rudman-Hollings, because there are some dangers. But let me just point out to you that all of you should be beating upon Members of Congress to ensure that we pass the budget. Because the way Gramm-Rudman-Hollings works, the only time that these across-the-board cuts take place is if Congress fails in doing what it is supposed to do. What we are supposed to do is pass the budget. And if we pass the budget, of course, that meets the deficit reduction targets, then these across-the-board cuts do not take place.

In any event, you indicated that we have a number of problems. And I think you did that quite well. I was not sure, however, exactly what you were telling us about what we need. If you were to pick out—and I know there are whole loads of things that you think probably are needed—but if you were to pick out one thing that you would want your Congressman, and at least a majority of the others to do to deal with the problems that you confront in the providing of health care, what would that be?

Mr. KLEYPS. I would have to say that it would be to concentrate on the needs of the homebound elderly, and that takes on many forms. Home-delivered meals are essential in this area. Case management, which is a relatively new product in this area, is extremely important in keeping people independent in their home. Home services that the Council on Aging provides, the personal care, homemaker, store service, and related services, designed to help those who are the most critical in need situations.

Overall, I think there needs to be support and supportive attitude from Congress, regarding senior centers in particular, and also regarding new legislation that may inhibit or restrict our ability to apply the dominant and the local agencies see the need for. We are not extravagent. We do not try to be extravagent in our spending patterns, in our salaries, or any of that type of thing. But we are caught up in interpretation of the rules, rather than servicing clients better than other issues—and I can go on and on and on. I do have major concerns in many areas.

But, I see a need, and basically a need for the home help, and a case management, as I indicated earlier, and the delivered meals, particularly.

Mr. **Tauke**. Thank you. Mrs. Neumann, you are a wonderful witness, and I love your spirit.

Mrs. **Neumann**. Thank you.

Mr. **Tauke**. Any time you are looking for a new place to come, we will welcome you to Iowa.

Mrs. **Neumann**. Well, it is easy to talk about the problems of senior citizens since I am one. I like to think of being recycled rather than retired. But all I am asking you people to do is support us in our endeavors, we have come a long way in 25 years. When I stop and think of what we had then and what we have now, and what we need is not so much more money, but we need to protect what we have already established. And please help us do that.

Mr. **Tauke**. And you have been a most articulate witness. Let me just say I like your emphasis on supervised living facilities. And one thing—I think I know what you mean, but why do you not, for the record, tell us what you mean by a supervised living facility?

Mrs. **Neumann**. I am talking about housing apartments, where everyone has an individual lifestyle, but where meals can be furnished right within the apartment building, where transportation can be furnished. Where there is a concentration that—they would get a call every day from someone within the establishment to check on their health and their basic needs. That the home health agency would feel free to work in such an establishment, because think of the miles that it would save. You know, some of these people have to go 20 miles to see 1 client.

Where, if we could get established this kind of an interim living, they would not necessarily have to be put in a nursing home. They could have independent living with all the support that they need.

Mr. **Tauke**. Are you aware of any facility like this in the——

Ms. **Neumann**. There is one being planned in our area now by the Lutheran Social Services. And they plan on buying a dormitory that belonged to Alpena Community College. And they are hoping that they can turn it into that kind of a facility. And I know that their first housing built in Ann Arbor has that kind of a setup, where there are meals furnished. It is called Lori Terrace. There are meals furnished, and when the person goes in there, they have to guarantee that they will take so many meals from the cafeteria.

It is working out beautifully. There is a home manager. There is a social services worker right within the area, and it does a terrific kind of thing to keep people independent.

Mr. **Tauke**. I just might observe that in my home territory in Dubuque, the churches got together and built a facility called Ecumenical Towers, which is just as you described, and it is a wonderful blessing for the seniors living in that area.

Mrs. NEUMANN. We are going to have to turn to our churches, to our agencies, to our organizations, to support us in this kind of thing. But we also need legislative help——

Mr. TAUKE. The Federal Government chipped in quite a bit on that, too.

Mrs. NEUMANN. Yes.

Mr. TAUKE. Several of you talked about some problems with early discharges, and so I am going to kind of beat that issue a little bit. And I think you offered a very good prospectus, Mrs. Neumann, about the relationship between hospitals and doctors and patients.

But I gathered from the comments that I heard, in the hospitals which are serving this area, there is no one who serves as a patient advocate within the hospital. Am I correct? Are you aware of patient advocates in any of these hospitals?

Mrs. NEUMANN. There is a peer review organization established in every State that is supposed to police the Medicare Program——

Mr. TAUKE. But in the hospital——

Mrs. NEUMANN. They are supposed to have a named person in every hospital, to whom a patient can turn to assist them in appeals, or asking the PRO to review that case. But nobody knows that person. You see, it has not been public enough.

I was in Wisconsin about 3 weeks ago, and about that time, HCFA broke the contract with their PRO, because they felt they were not doing a good job. I have asked around in Michigan, the different groups that I have spoken to, and nobody knows what a PRO is. And we have five offices in the State of Michigan. One is in Travis City. This region is in Travis City. And these people should demand a review by the PRO if they think they are being discharged unnecessarily.

We have a right to appeal, and we have a right to talk to people. But if we do not tell people that this is available, they might as well not even exist.

Mr. TAUKE. Well, this has been a wonderful panel, Congressman. I guess it is on to the providers.

Thank you.

Mr. SCHUETTE. Thank you Mrs. Newman, Mrs. Schuler, Mrs. Duckworth, Mr. Kleyps. Thank you for your very informative, worthwhile, and stimulating testimony.

I would like to call our third panel up, if I may. Wilma Shurlow, Joseph Smith, Dr. Harrison, Dr. Hoelzel-Seipp, and Dr. Pattullo, please?

Mr. SCHUETTE. Ladies and gentlemen, I think we will commence our third and final panel for this afternoon.

We have heard from advocates, area agencies, and county councils on aging, and leaders in the senior community. We have also heard from beneficiaries—patients who have utilized health care facilities in the area, in northern Michigan and mid-Michigan.

Now, we also have an opportunity to hear directly from health care providers.

Before I introduce our five panelists, I would like to take this opportunity to introduce Senator Connie Binsfeld. Connie, would you please stand just for a moment?

Mr. SCHUETTE. Senator Binsfeld represents the northern Michigan area. She goes shore to shore, from Michigan to Huron, and has just been showing an exceptional leadership in the State legislature and in the State senate on issues important to our retired population. And Connie, thank you for being here, Madame Senator.

Our first panelist will be Wilma Shurlow, who is from Clare County, and is the director, owner, and manager of Clare Nursing Home. Mrs. Shurlow, if you would please, in the interest of time, we have about 49 minutes before lunch is served here. So what we might want to do, in order that Congressman Tauke and I can ask some questions, summarize highlights of your statement, which will be included in its entirety in the record. And that way, we may proceed to gather information in the best way, plus elicit some additional questions.

Mrs. Shurlow.

PANEL THREE: CONSISTING OF WILMA SHURLOW, R.N., DIRECTOR, CLARE NURSING HOME; ROBERT E. HARRISON, M.D., MEDICAL DIRECTOR, HOUGHTON LAKE CLINIC; LILO HOELZEL-SEIPP, EXECUTIVE CODIRECTOR, MICHIGAN HOME HEALTH CARE, INC.; JOSEPH M. SMITH, PRESIDENT, GLADWIN AREA HOSPITAL; AND DOUGLAS PATTULLO, CHIEF EXECUTIVE OFFICER, TOLFREE MEMORIAL HOSPITAL

STATEMENT OF WILMA SHURLOW

Mrs. SHURLOW. Thank you for the opportunity to come down here today.

As indicated, my name is Wilma Shurlow. I am a registered nurse, with a master's degree in education. I am a certified fellow of American College of Health Care Administrators. And for the last 20 years I have been involved with the elderly as administrator and owner of a skilled nursing home, currently with 129 beds, in Clare, MI.

I have seen a lot of changes in the last few years. There are a lot more nursing home beds available, and we have much more modern facilities. Many of our facilities are really geared to taking care of that in our skilled care—the hospital skilled care, as well as long term, basic care.

And Medicare defines skilled care rather narrowly, and necessarily so. We used to get a basic skilled care. Now that is very rare, because the Social Security Administration had to redefine what skilled care was. So most of the patients I take care of, even though I am a skilled facility, are in the basic category, which Medicare does not pay for. In our area, most of our folks are Medicaid. Medicaid does pay for skilled and basic. And that is pretty hard on our senior citizens, because a lot of them have to use their own resourses before they are eligible for Medicaid, and it does not take very long to exhaust those resources.

There have been some abuses of the Medicaid system. We have been really fortunate in our area. We have good family relationships, and our families are involved and anxious about care and are genuinely caring.

I believe that the fact is that if the State pays the bill for the care of the elderly, a State then should not go into other family members' pockets. And I think a great deal of abuse occurs in that area.

People do not want to work all their lives, work hard, have a small estate, and see all of that go down the drain. With just a small critical illness. over a few months, and it will be all gone. On the other hand, our taxpayers do not want to pay for all of that care, and have their assets go to everybody else, who had never provided any care for them.

It is a fiscal and moral dilemma. And something that you see a lot of with our older people. I am glad to say that in our area of Michigan it does not happen very much.

Sometimes our elderly couples have demanded so much from their children, as related in Mrs. Neumann's statement. We have an elderly couple who celebrated their 81st wedding anniversary in our nursing home. They had an 81 year old daughter that had to do all the running for them. And they demanded so much. They are a delightful couple, but they just ran her ragged. She literally gave her life for her folks, because she died shortly after both of them died.

Also, I think we lay a lot of guilt trips on our families who really try hard to take care of their people. And they do have to make decisions to put somebody in the nursing home. That is very traumatic for them. Not only do their parents tell them never to do it, they have thought they never wanted to. But the percent of bad things that happen in this area is very small, and I think the industry image is changing, and I am grateful for that. Because we are doing a lot more things to help have a better image so that people are not afraid anymore to put their patients in a nursing home.

The industry is also faced with problems of abuse. If there is abuse of a patient, a staff member is found out, you sometimes fire that staff member. There have been incidents in one of our facilities where, because of a labor dispute, they had to hire that person back and pay them a lot of back wages. So, in the meantime they got written up in the paper and got a bad name for patient abuse in the hospital.

But also, the misuse of liability insurance and workman's compensation—all have an effect on the cost of care, and our ability to keep the costs lower. In our workman's compensation charges, I was faced with an increase to $4,600 a year, because I had one employee who had back surgery twice. I felt the claim was legitimate, but because that employee used that insurance, they said either we will cancel you, or we will put you in a pool. So I switched then to our State Association, self-insured. But it is just a difficult time.

As far as regulations, do we need more regulations in the nursing home industry? And my answer is an emphatic no. Nursing homes are the highest regulated industry in the Nation. And our association says it is next to nuclear, but I am not so sure about that. But regulations do not necessarily guarantee good care, anymore than the Ten Commandments govern morality. They are guides that we must have, that are necessary. And hopefully, they will help us avoid some of the problems that we have in the industry. I am all for regulations. They are absolutely necessary, and so are audits and inspections, and I welcome them. But I do think we spend more money than we need to on it.

Health care, in itself, is so expensive. It is not getting any cheaper. And everyone is going to watch to have a piece of the pie and in the political arena there is going to be squabbling over who is going to get the money and how much of it.

Hospital beds are going to be closed. I think our American Health Care Association said there were 18,000 hospital beds closed last year. Others are going to be empty and they want some of the action. How to use those beds. Already cheerleaders are on the rise. Thank goodness for that, and we are really proud of the things we have been providing in our rural communities as we have heard this morning.

Equitable health care, devices, equipment, outpatient clinics, spot-care, and this has really, really been necessary but not all of that is cost-effective.

And all of this is directed to those we have already referred to as the Golden Age Americans, and is a big target for all of us in the business, and for our patients, who either want the business, or want the growths. We already have, in the over 65 group, about 28.53 million people. And I read just last night that between 2010 and 2030, there will be 50 million. This is the largest generation that this country has ever produced in the elderly, over 65 years old. They already outnumber the 18 to 24 group.

And of course, illness, the long list of disabilities, the boredom, the poverty, they are all begging for solutions. And you have already heard some of the wonderful solutions. And the payment that has to be made by the patient is greater now. Even the part that Medicare will pay has increased. I kind of liked your IRA idea of putting it into a tax-deductible account for your older years.

But still, a lot of our elderly people are more affluent, and better off than they have ever been in any generation. And some of the young people are struggling to raise families, and pay their bills. So, if you think about tax dollars, and shifting to the elderly population's needs, we have to consider what does that do to the people who are paying the taxes?

Our politicians will have to be, and I am sure they have been informed, more and more involved, not only with trying to meet the needs of us as constituents, but they have to astutely weigh the issues, as to their economic impact for those who are paying the bills for services.

Do our rural elderly have what they need? And I know, and you have heard that there are many unmet needs. In the nursing home district in our county, we have enough beds, at the present time, and will continue to need public transportation. Our county has a transportation resource, and we are really proud of that. In the nursing home industry, we have always been required to provide transportation for anyone who did not have transportation. And I have, for years, taken my people to the dentist, to the foot doctor, to whatever they need——

Mr. SCHUETTE. Mrs. Shurlow, if I may, could you take 1 minute to summarize? I want to make sure that we all have an opportunity to make some statements. Of course, I am anxious for questions, if I may.

Mrs. SHURLOW. OK. I just want to say, then, in closing, that I am really proud of Michigan. I think that we have tried harder than most of the States I have been in, to really try to meet the needs of our elderly people. I am proud of the facility we run, and the community services we have. The questions are: what can we do for you, what do we need, what can we afford, who is going to foot the bill?

We are our brother's keeper. We are all very much involved in this together, and we need to continue to be, because it is a very important question.

Thank you.

Mr. SCHUETTE. Thank you very much, Mrs. Shurlow.

Our next panelist who will testify is Dr. Robert Harrison, a doctor in the Houghton Lake area.

Dr. Harrison, welcome to our panel. Welcome to our factfinding mission of the Select Committee on Aging, and the Task Force on the Rural Elderly. Doctor, I have read your very detailed letter, dated March 1. In the interest of time, could you please, doctor, highlight your views as a medical practitioner in this day and age of trying to balance the competing goals of reasonable costs and quality care. Could you take a moment to enlighten us, sir?

STATEMENT OF ROBERT E. HARRISON, M.D.

Dr. HARRISON. I thank you for inviting me. I have been practicing medicine for about four decades, and I have had my Mother's Day call to my 92-year-old mother Sunday, and I told her that I was going to be investigated by the Congress. And she said, what did you do wrong? And I said I lived too long. She said, what do you mean, Bob? I said they think I am an expert on treating the elderly. She said, well, if that is true, why the hell am I so unhappy. My mother lives in Florida, has a very nice situation, but unfortunately, her sons are not in Florida. So mother is not happy. Mother will come and visit us this morning. With 92 years I am not sure she is going to be happy. And I think her comments are pretty good, even though I am an elderly person, I do not know that anybody really is an expert in the treatment of the elderly.

The elderly are grown up kids, really. We just live longer. I am going to make this short.

My interest in this area is to provide quality health care, through a local office setup. Our interest is to avoid hospitalization when it is possible and compatible with good care.

We are anxious to provide a variety of services through the office, and we have worked out a schedule for specialists to visit the office at different times of the week.

I think that the day of the ivory tower is probably gone. I think that tertiary care facilities are going to be necessary, but I think the rural hospital is facing some real tough days ahead. I am sorry that the doctors and the hospitals are getting the burden, in terms of some regulations that none of us really wanted, and are now being forced to be the policemen for these regulations. This is not a comfortable position to be in. This creates an adversarial relationship that I do not think the doctors and the patients should have.

Locally, I think that we need an emergency medical service and we are going to work very hard to help bring this about. While they are in two local hospitals, which are Grayling and Tolfree, we are going to be involved in terms of helicopter transport in this area. We have a very excellent highway system, which goes north and south, and does not go anywhere except straight south. It does not go anywhere near any hospitals. It would be nice if we had some lateral highways that would connect us from east to west.

One thing I wanted to say is that one of the inevitable aspects of the aging is at some point in time we are going to die. And I think that as I approach that uncertain date myself, the most important thing to me is that I wanted to be treated with dignity. I want to be treated with love. And I do not want people doing a lot of unnecessary things to me. So, on that note, I will quit.

[The prepared statement of Dr. Harrison follows:]

PREPARED STATEMENT OF ROBERT HARRISON, M.D., MEDICAL DIRECTOR, HOUGHTON LAKE CLINIC

I am happy to submit to you some of my thoughts about health care for mid-Michigan's rural elderly. It is my opinion that the elderly deserve quality health care within their own communities. I feel that the pendulum is swinging back to the time when the majority of health care needs were addressed within the physicians office and that, even though the technical resources available to physicians this day and age has increased dramatically in the past two decades, that these technical resources can also be made available within the physicians office. At the same time, I feel that the community needs to be informed as the availability of such services as well as what services can amount to in terms of improving the quality of their life. I have long felt that the availability of health services is the corner stone of providing health services and to accomplish this availability the hours of operation of a health care facility need to be tailored to the needs of the community, rather than the convenience of the providers. Health care services need to be provided within a reasonable distance from the patients home and follow-up care should be provided by home care where necessary. Local public transportation services need to be continued. Much can be done with the preventive services and the elderly through educational services as well as group oriented activities. We are finding that as our medical skills increase that more effective medications become available for treatment of those ailments common to the elderly, however, these medications though more effective are also substantially much more expensive. It is not uncommon that we find the retiree on a fixed income, facing a budget expense on a monthly basis for medication exceeding their budget for food. We are continually seeing elderly patients who decrease the size of their dose of medication in an effort to reduce their monthly costs of these medications and we see physicians not prescribing the most effective medication for an individuals condition because of the cost of that medication. Out of pocket costs to the Medicare recipients are escalating and we are hearing that benefits are to be reduced.

I am very favorably impressed with the growth of community support services over the past two decades, however, I feel that there is a definite fragmentation of activities among these support services, so that frequently there is overlapping and duplication of services which is unnecessarily costly. A recent survey in this Northern Michigan area shows that community services such as: Telephone check in, chore services, home medical alert, halfway houses, and home health services are priority items. We learned in the last five years that many of the services that we though could be provided only by the local hospital, and indeed be provided on an out-pateint basis. It is unfortunate that this realization has been mediated by the application of stringent rules limiting the length of time that the elderly patient can be treated on an in-patient basis. The application of these rules and the necessity to operate within these rules is, in my mind, producing a situation where the elderly are receiving insufficient hospitalization for a given condition. The guidelines do not, in my opinion, allow for the fact that the elderly do not recover as rapidly as possibly a younger person might and that too commonly the elderly do not have home support services that might be available to a younger family. In our patricular area we are dealing with some circumstances which, I believe, are peculiar to this area in that an unusually large portion of our pateints are elderly and are primarily retirees who have elected to retire to an area some distance from the area in which they lived during their younger years. I think that this is due to a number of reasons, one of which being that they feel their retirement dollar goes further in this area, as well as the fact, that many as retirees spent their vacations in this area and developed vacation homes in this area, with many pleasant memories of their past association. Other folks have told me that the old neighborhoods in the metropolitan area have changed and that they felt threatened by a lawless element in their old neighborhoods and retired to this rural area in response to this fear. No matter what the reason, many of the retirees are displaced from old associations and really don't know where to obtain necessary services

It is also true that many young practitioners see the rural area as a desirable spot to establish a practice. Many of them are totally unfamiliar with the rural experience and find that the metropolitan areas are more desirable after a short time and leave for what they consider greener pastures, leaving behind the population that had come to depdnd on their services. I think the one most common question that patients ask me is whether I plan to stay in the area. I think this indicates a need, in the elderly, for consistency in their relationships especially since many of our population have really up-rooted their lives during their retirement years.

The most pressing problem, I see, in terms of immediate needs is for a unified emergency medical service involving at least three county area and possibly four. The service is currently fragmented and under no central control. The primary correspondent hospitals for Roscommon County are: Tolfree Hospital in West Branch, Mercy Hospital in Grayling, and Mercy Hospital in Cadillac. I would feel that a coordination of the emergency medical services in this area would be a priority item and should be pursued as rapidly as possible.

The majority of tertiary care facilities are located in the sourthern one-third of the state and it creates a real hardship for the elderly to travel when needed to these tertiary care facilities. The Munson Hospital group and the Burns Clinic group of Northern Michigan Hospitals are developing extensive tertiary care facilities and this is going to be of considerable assistance to our aged. A problem, however, will remain in terms of transportation from our area since the major highway systems are currently only north and south and do not closely approach these facilities. I would suggest that some thought be given to highway planning to allow development in east and west running routes, connecting with the major I-75 expressway.

The long term impact of the malpractice litigation issue is bound to effect the care of the elderly because we find that many of the very competent providers are setting up practices in states where there is a better malpractice climate. The public is beginning to realize that this whole liability litigation issue is not confined to a few "bad doctors", but involves the entire spectrum of practitioners and other local service providers. It may be of some interest that 40 years ago next month my first malpractice premium, to cover my first year in practice, was $18.00. I realize that there has been some inflation over the last 40 years, however, this escalation is ridiculous. The malpractice premium costs will be passed along to the consumer in one way or another. The most drastic impact that this ridiculous set of affairs produces is the massive numbers of unnecessary x-ray and laboratory examinations required, not necessarily for the benefit of the patient, but to protect the liability of the provider. In my opinion it is necessary, immediately, to have some legislative relief from this unnecessary litigation.

One of the inevitable aspects of dealing with the elderly is the certainty that at some point in time our patient is going to die. As physicians we are trained to relate to that in an adversary sense and it is only when we approach this certainty ourselves that we can understand that death can be a blessing and there is a great deal that can be done to make this final event of a life time dignified and meaningful for the survivors. I feel that there should be a partnership of effort of those parties concerned to make this last event pain free and tranquil. The hospice effort has made great strides in this area. I think, however, many times life is extended unnecessarily by technical expertise because clear cut legal and ethical guidelines have not been established.

Thank you for allowing me the opportunity to present my personal views regarding the care of the elderly in a rural area.

Mr. SCHUETTE. Dr. Harrison, thank you.

Our next panelist is Dr. Hoelzel-Seipp, from Traverse City, who is the executive codirector of the Michigan Home Health Care, Inc., which provides medical, nursing, and housekeeping services in a patient's home. Dr. Hoelzel-Seipp, I thank you for being here. Any statements that you want to include in our record, indeed will be.

If you would, Dr. Hoelzel-Seipp, summarize three or four aspects, in terms of the health care that you provide an individual—in a patient's home. And then Congressman Tauke and I will be able to ask some followup questions.

STATEMENT OF LILO HOELZEL-SEIPP, M.D.

Dr. HOELZEL-SEIPP. Thank you for the opportunity to discuss some additional points to the ones made in the testimony that has been provided to you by one of our unit directors, Ms. White. I am the executive director of Michigan Home Health Care, and I am also the president of the Michigan Home Health Assembly, which represents the home health care agencies in the State of Michigan. So, I feel that I am very familiar with the concerns and the problems of home health care, which are quite different from the way we have been talking about home health care this morning.

What so-called certified home health care services provide, among their abundance of services available in this area and in this State are, nursing services, physical therapy, occupational therapy, social work services, speech pathology services, and home health aid services. No housekeeping services are part of Medicare benefits.

What we are seeing, or what is happening to home health care, is difficult to describe in a few words. The problems seem to be related to the change in the reimbursement system for hospitals.

Let me tell you how those problems affect home health care.

We do see an increased number of referrals—of sicker individuals because of earlier discharge, which is not a determination of the hospital. We are seeing an increased number of referrals, because patients are not admitted as readily to the hospital as they used to be. And I think we have heard some examples of this in earlier testimony.

We are seeing a different kind of referral of individual, because of the rather stringent regulations which are in place for readmission of patients for the same conditions, to hospitals. So, the makeup of the client that is being served through agencies like ours, has changed. We are seeing a much sicker individual. But we are only allowed to see that individual for a shorter period of time than we used to. And that means the pressure is on those home care services which we talked about this morning.

They are discharging patients earlier and overextending the services available through the senior network.

The Health Care Finance Administration has created something that is called intermittent care, or medically not reasonable and necessary services, and has increased the number of denials to such a degree, that of our five offices, just to give you an example, we have four that just last week, lost their waiver of liability. To some of you that might have some meaning. This means services that are rendered in good faith by the agency, are no longer reimbursed by medicare, or no longer covered under this waiver because the Federal Government says you have provided services to patients who were not sick enough.

We have not changed our care criteria. We have not changed the way we are providing services. But the way in which claims are being reviewed has changed, and we are looking at a mountain of denials.

In 1984, we had 12 agencies in Michigan off waiver. In 1986, we have over 100. And that is not because agencies have changed, or patients are less sick.

I must tell you that Mr. Corson, who testified this morning about his wife—his wife would not qualify for home health care services under Medicare, because she has no potential for rehabilitation, and she will not show any progress. Therefore, he is, indeed, running a nursing home of one on a 24-hour basis. It is not that the services are not available. They are not reimbursed under Medicare.

Medicare has created something that is called reimbursement by discipline, which will result in a reduction of services available, because agencies will not be able to afford, on an average basis, to provide specialty services, such as physical therapy and occupational therapy because reimbursement methodologies have changed. And I will not go into detail explaining that.

The Health Care Finance Administration has chosen to administer the Federal guidelines in a way that is different from provider type to provider type. For example, HMO's do not need to meet the same certification requirements. The services which are rendered, can be rendered by personnel less qualified than those with qualifications which must be met by home care agencies.

The quantity and quality that HMO services have to provide does not have to compare to those which have to be provided by certified agencies.

What I believe is happening is that the Health Care Finance Administration does not administer the benefits as it was congressionally intended. If we save on a hospital stay by reducing the length of stay, we must have an alternative. We cannot simply say patients have to go home earlier and then have to struggle. There has to be some service available on a community basis. It is very fine to save and I am looking forward to HCFA telling us what we have saved. But I think we have to stake some of that somewhere.

Mr. SCHUETTE. Excuse me, I smell the tuna fish casserole, and I think this is the first signal from Ms. Berry. Please, if you could summarize.

Dr. HOELZEL-SEIPP. Yes. We need to have services for those clients who suffer from a chronic deteriorating condition. We are all going to live longer, we are all going to suffer from chronic, deteriorating conditions. There are no services available.

Yes, Congressmen, please cut the budget, because whatever this lovely—what is it called?

Mr. SCHUETTE. Gramm-Rudman.

Dr. HOELZEL-SEIPP. Gramm-Rudman already has hit. We are getting reimbursed 1 percent less, currently, than costs. Costs. I do not know how to do that. Because Congress does not pass a budget. And HCFA says we have to save money, somehow. So please, pass a budget.

[The prepared statement of Dr. Hoelzel-Seipp follows:]

PREPARED STATEMENT OF LILO HOELZEL-SEIPP, PH.D., R.N., EXECUTIVE CODIRECTOR, MICHIGAN HOME HEALTH CARE, INC.

Members of the Select Committee on Aging, senior citizens and those concerned about senior citizen issues.

I am Lilo Hoelzel-Seipp, Ph. D., R.N., the Executive Co-Director of Michigan Home Health Care, Inc. Currently I am also serving as the President of the Michigan Home Health Assembly, which represents the home health care industry in the State of Michigan.

It seems that the most common concern about the Medicare benefit, namely, the diagnosis-related group reimbursement for hospitals and its consequences for individual patients, their families, and the community-based service network has been discussed in great detail. There is nothing I could add to the issue that has not already been said. I would like to focus on the impact of DRG's on home health care services, namely so called skilled home health care services through Medicare/Medicaid certified agencies. Such agencies, including Michigan Home Health Care, Inc., by and large, provide nursing services, physical therapy, occupational therapy, social work, speech pathology, and home health services. Rural agencies, in particular, are having a caseload which consists of about 80-85 percent Medicare patients making Medicare reimbursement and program limitations particularly significant for our agencies and the services we provide. A clinical staff member of a rural home care agency drives on the average between 20-28 miles to see a client to provide direct services. There is a sufficient provider network available in the rural and non-rural areas of Michigan to provide the type of services clients would need following discharge from the hospital. However, the reimbursement for the services needed is not there because the program eligibility criteria are being tightened by the Medicare administration every day so that I may say to you that the patients who have been testifying here today complaining about the absence of services following discharge would most likely not qualify for the Medicare home care benefit given the Federal guidelines or their current interpretations. What we are seeing in the area of skilled home care is an increased need because of earlier discharge and because of more stringent admission criteria to the hospital setting as well as the critical view that is taken when a Medicare patient needs to be readmitted to a hospital for the same problem.

What is Medicare doing to the home care benefit? It appears as if Medicare is making a very serious effort in dismantling the benefit available through:

1. Increased denial:

Care that is provided for is suddenly no longer deemed to be intermittent or "medically, reasonable and necessary". In 1984, 12 home care agencies in the State of Michigan had lost their waiver of liability status while today some over 100 agencies are affected, including four subunits of Michigan Home Health Care. We have not changed the way in which we are providing services nor have we changed our admission criteria or our documentation. What has changed is the interpretation fiscal intermediaries are forced to make when medical treatment plans are submitted to them.

2. The reimbursement mechanism for home health care agencies has changed from an aggregate reimbursement, subject to cost limits, to a discipline specific cost limits which will force agencies to discontinue specialty services. Such services are, in particular, social work, physical therapy and speech pathology.

3. HCFA is developing bonding and escrow requirements for home care agencies which will place an undue costly burden on home care agencies, and probably will force smaller, particular rural agencies to discontinue service altogether.

4. HCFA is now in the process of calculating the new cost CAP's for the year 1987 and is basing its calculation on 1983 service data, although the 1984 data are in. The 1983 data base is the pre-DRG data base, which is not reflective of the increased costs

home health care agencies experienced because a sicker patient population has been cared for. Much less do the 1983 data reflect the cost due to the HCFA form process of 485, 486, which is estimated to add another two or three dollars to the cost of each home health care visit.

5. Finally, there is definitely an unequal application of Medicare requirements by auspice. For example, health maintenance organizations do not need to meet the same certification requirements as other home care providers.

Let me conclude with just making a few suggestions:

1. I am appealing to your responsibility as far as oversight is concerned, and I am asking you to see to it that HCFA administers the Medicare benefit implementing the original Congressional intent.

2. If we save on hospital costs by reducing length of stay, Congress must recognize that an alternative for the more expensive hospital care must be available. Less restrictive and less costly care through community based agencies, ranging from skilled to basic care, and including chore services and respite care for patients and their families must be made available if the senior health care program is to resemble a health care system.

3. Home care services for patients suffering from chronic deteriorating conditions must be made available. The current Medicare home care program is only available to those suffering from an acute illness or a very acute flare-up of a chronic condition providing progress can be shown and a rehabilitation potential exists. As we are all growing older, we will be suffering from chronic deteriorating conditions more so than acute illnesses and need some coverage and some services for those long term needs.

4. Discharge planning, which is the legal responsibility of hospitals, and home care coordination, are a must and should be mandated to be performed by existing providers without additional cost and without the creation of new programs and administrative costs, such as case management programs.

In response to the specific questions you have raised, as to the need of making available additional services, I'd like to comment as follows:

I feel that there is a good and rather complete service network available, but what is missing is appropriate funding for those services that have been developed. I do not believe that the creation of additional, or new services, which again will require funding and create new administrative costs, would be useful and helpful in solving our problems.

You asked about liability insurance and home health care. Liability insurance rates, as well as Workmen's Compensation rates for home health care agencies, as for all other health care providers, have sharply been increased. For example, we experienced a forty-six percent increase in the premium rate for Workmen's Compensation since we were thrown into the state pool, after having lost Workmen's Compensation coverage following a legitimate Workmen's Comp claim. Professional liability rates have almost been doubled in the last year, and are focing us for the first time ever, to carry less than maximum professional liability insurance.

Thank you, members of the committee, for the opportunity of testifying before you.

Mr. SCHUETTE. Thank you, doctor.

Our next witness will be Mr. Joseph Smith, who is president of the Gladwin Area Hospital, which is a 42-bed hospital that is not far away from here.

Mr. Smith, I welcome you to our committee and our hearing this afternoon. I have read, in detail, your statement, which will be in the record fully and completely.

Mr. Smith since we also have the administrator from Tolfree Hospital to make some comments if you could summarize some thoughts for us. I want to make sure that both Congressman Tauke and I are able to ask some questions. Thank you for being here.

Please proceed.

STATEMENT OF JOSEPH M. SMITH

Mr. SMITH. Thank you very much. I presented my report to you, and it contains a number of items, and I will try and just summarize particularly the recommendations section of it.

But, listening to some of the other speakers here, it is important that I am able to say one thing. I think health care is really a system. What we have been talking about here are functions of the different components of the health care system. Each one appears to be working to the best of their ability to provide services for the people. However, I think my major concern is who is coordinating all those different components, and who is making them work for all the individuals, particularly the elderly. I think that is a challenge that health care is going to be facing in the future.

Rural hospitals really are only a part of that system, and I must point out that they are an important part of the system. It is the focus of health care for many people in the smaller communities. Without the small community hospital, I think health care in some of these communities would really be put at some disadvantage.

I just want to cover a couple of recommendations that I made in my written report to you.

As I was glad to hear Dr. Harrison say, he feels that rural hospitals are really in financial trouble, and they are in trouble in a great way. I think what needs to be done is we need to convince HCFA, or Health Care Finance Administration, that rural hospitals are in trouble, and seek some sort of alternative for financing rural hospitals.

We need to have some incentives to have physicians practice in small communities. There is no way that a small community hospital can survive unless there are physicians who are there, actively practicing, particularly in areas where there are a number of elderly people living in the community. These physicians need to have an interest in geriatric care.

The next thing I would like to see is that some very specific issues be addressed, and some corrections made to the malpractice insurance problem. It is important to point out that hospitals pay a tremendous amount for malpractice, in addition to the physician.

Most importantly, though, I think there has to be someone and some way that there is a required coordination of health care services, so that elderly patients, all patients for that matter, have a clearly delineated way to access the system, to find out what is available to them, and to find out how they can get in and get out of the health care system and feel better when they are finished.

I think that it would be important, particularly in the State of Michigan, to allow some sort of transitional beds, some sort of transitional care beds, or swing beds, or whatever we want to call them, so that patients that really do not need the care given in hospitals specifically, and are not well enough to go home, have some place to go. The patient is left in the middle. Either the patient ends up staying in the hospital, and the hospital is unable to be reimbursed or the patient has to go home and become a burden to their family. These transitional beds are very important.

In summary, I do not think that the health care system is doing a particularly bad job of taking care of the elderly. I think what we really are faced with is the situation in which the health care system needs to coordinate its efforts with the agencies—perhaps the agencies that are sitting right here at this table—and all the other agencies throughout the area so we can provide adequate services to all people, particularly the elderly.

Thank you.

[The prepared statement of Mr. Smith follows:]

PREPARED STATEMENT OF JOSEPH M. SMITH, PRESIDENT, GLADWIN AREA HOSPITAL

HEALTH CARE FOR THE RURAL ELDERLY: What the Future Holds

If you are elderly, you live in a rural area, and are in need of health care, where do you go for treatment? The obvious answer is to your physician or local hospital. But will that always be the case? Developments over the last two years could so severely impact the long-term viability of small local hospitals that the services once taken for granted may no longer be available.

Because the elderly population requires such a broad array of health care services it may now be more important than ever to carefully evaluate the effect of state and federal regulations on the small local hospital and on non-acute care facilities and services. This evaluation must occur before these facilities are forced to reduce services, or close altogether.

Reimbursement levels are so low and the amount of expense incurred to manage the regulatory process is driving many organizations to the brink of financial disaster. The victims of such a system are very often the elderly or the poor who have very little flexibility in their choice of health care providers. This paper will address some of the problems now emerging, as well as some of the potential issues that we will face if the system of providing health care in rural areas is not improved. The major focus will be on the elderly patient, but the issues can apply to virtually all consumers of health care in rural areas.

I. ACCESS TO CARE

It goes without saying that the primary entry points to the health care system are through the family physician and the hospital emergency room. Both of these access points are in jeopardy at this time.

Physicians - Rural America has not experienced the glut of physicians that other areas have seen. In fact the difficulty of attracting practitioners to low population areas is now acute. The local hospital frequently must step in and financially support a new physician for a period of time in order to attract them away from lucrative urban practices. A less than adequate number of family physicians results in long lead times needed for appointments and lengthy awaits in a doctor's office. Neither of these situations makes access to care for the elderly convenient or reasonably easy.

A growing number of physicians are becoming disenchanted by the reimbursement system and the high cost of malpractice insurance. Some will leave their practices without finding a replacement. For an elderly individual, finding a new doctor can be very traumatic and frustrating. Rural hospitals have to become more involved in the process and usually will not have the financial resources to accomplish the task.

Emergency Room - A viable emergency room is critical to the health care delivery system of any community. Increased financial pressure on the rural hospital makes it very difficult to maintain a fully staffed emergency room. Loss of a community hospital emergency room can be a serious problem for the elderly, which results in long and expensive ambulance trips and hospitalization in a distant facility. The inconvenience for family members, who are often elderly as well, can actually prevent them from visiting while the patient is hospitalized.

Access to other health care services is frequently hindered by a lack of coordination between agencies. The system is fragmented and leaves large voids where the elderly patient is frustrated in his attempts to receive needed services. While it is impractical to have one agency control all health care services in a community, someone must be responsible overall. Profitable lines of health care business are being aggressively pursued by many competitors, but the less profitable ones are left to flounder or fail. The ideal situation would be to have one agency as the informational focus for all services. That can't happen when there is no incentive to cooperate.

II. AFFORDABILITY OF CARE

Can any business continue to provide products or services if the reimbursement they receive is below their cost? Certainly not. Rural hospitals are being forced to do just that. Many of their patients are elderly and subject to the DRG rate. There are very few charge paying patients to absorb the difference. How long will hospitals continue in business? How will they be able to replace plant and equipment and maintain a quality staff of professionals?

The elderly patient becomes the victim of this trend. Rural hospitals will have less than state of the art equipment. They will not be able to attract professionals who desire a strong facility in which to practice. The patients will then either receive substandard care or will be transferred to a larger facility, causing inconvenience for the family and the patient, as well as increasing the cost.

It is reassuring to see small hospitals joining other larger hospitals or hospital systems. This trend will create economies of scale, and financial security. Communities should support this trend and government should create incentives to facilitate it.

III. CONTINUITY OF CARE

Much lip service is given to continuity of care. Every agency professes to have the ideal arrangement. The reality is that patients must struggle through a jungle of regulations, forms, programs and providers to achieve the continuum of health services they need. Any patient that has had the need to progress from acute care to extended care to home care can testify that not only is the coordination between these elements poorly defined, but the care standards vary greatly between them. Only after a bad experience does a patient realize that he or she made a poor choice.

The solution does not lie in more regulations, meaningless transfer agreements, and other pseudo-arrangements. The answer is in a genuine cooperative effort and uniform standard of care and documentation. Transition between levels of care should occur smoothly and without any substantial deterioration of the care received. Elderly patients are more susceptible to these problems. Understanding their options for health care is not always easy for them. Are we really meeting their needs, when they are merely ping-ponged from one agency to the other? What is needed instead, is an effective system of networking between health care providers, such that the patient needs are met in an orderly manner, with quality being a high priority.

VI. MICHIGAN SPECIFIC PROBLEMS

A. Swing-bed program

The regulations for swing-beds or transitional beds in Michigan are effectively putting elderly patients in limbo. Since hospitals cannot use excess bed capacity for extended care, and since there is a shortage of extended care beds, particularly in rural areas, patients often must leave the hospital and go home where they are either unable to care for themselves, and consequently put a burden on their families, or must stay in the hospital until a bed is available. When a bed becomes available, it is often in a distant city, creating many transportation problems for the patient and the family.

From the hospital's perspective, the patients that stay until a bed is available causes significant drain on resources. Further eroding the financial stability of the organization.

The solution is simple. If nursing home care is needed, allow the hospitals to be reimbursed at the nursing home rate until a bed is available. Hospitals have the space, people and systems to provide excellent extended or transitional care. Hospitals don't want to compete with nursing homes, they just want to make part of their facility, which would otherwise be unused, available for patients that cannot be accomodated by the long term care facilties. Wouldn't it be better to keep a patient in the local area, so the family and friends can visit, instead of exporting them to a strange location? Doesn't it make good business sense to utilize the capacity of the rural hospital to meet a documented need for extended care? The Legislature in Michigan must take a stand in this matter. The reimbursement for extended care patients could make the difference between financial success or failure of the small rural hospital.

B. Peer Review rganizations

It is clear that Peer Review is necessary, however there are significant inconsistencies in the process that appears to work in opposite directions when you deal with the elderly patient. The necessity of admission cannot always be reduced to a black and white solution. Many patients can be effectively treated as outpatients, and they do very well. Others with the same problems may need more supportive care, that can only be provided by an acute care setting. MPRO will frequently reject payment for that patient when the chart comes up for review. There is no question that everyone in the health care industry must use the resources judiciously. When patients are caught in the middle it probably indicates that the system is inflexible, and is not meeting the objectives it has established.

It is often the hospital that is refused payment, and must communicate to the patient that there bill will not be paid by the insurance. For elderly patients these things are extremely difficult to understand. Is it the purpose of MPRO to so tightly restrict the use of inpatient care that hardship is experienced by elderly patients of the community? Or does MPRO have no concern for the for the hospital's financial security when it rejects payments for services provided.

The solution to this dilemma for elderly patients is not easy to determine. Perhaps the longer term effects of such a rigid system will prove that it is not good for the elderly. Unfortunately, by the time the realization of the effects of the system are felt, it may be too late for many small hospitals, and it may be too late for many of the patients as well.

V. RECOMMENDATIONS

Solving these problems is not easy, but they must be addressed with concern for the elderly patient and for the organizations that provide their care. The following measures, I feel would ease this situation.

A. Convince HCFA that rural hospitals are in trouble, and seek a different payment structure for them.

B. Provide incentives for physicians to practice in the rural areas, and to concentrate on the care of the elderly.

C. Enact measures that effectively deal with the malpractice insurance crisis, namely Tort reform.

D. Provide adequate support for rural hospital emergency rooms, particularly those in areas with a high concentration of elderly patients.

E. Require coordination of health services, such that the elderly patient has a clearly delineated system from which to choose health care services.

F. Provide incentives to allow small hospitals to join larger systems, by allowing the assumption of debt guaranteed by federal agencies.

G. Encourage the State of Michigan to enact workable swing-bed legislation that would allow hospitals to use empty acute care beds for extended care in areas where such beds are in short supply.

H. Assess the role and function of MPRO, with regard to the determination of necessity of admission for elderly patients.

VI. SUMMARY

Although this document would indicate that there are significant problems in the health care delivery system for the elderly, it must be noted that there has been some progress, but it may be too little, too late. Many organizations are taking a leadership role in these matters, and many are successful. However much more must be done, and the unique needs of the elderly cannot be reduced to terms so simple that a system of care only recognizes the cost of care, not the quality of care. The State and Federal government must look beyond the larger metropolitan health care systems, and inspect the plight of rural health care, which is struggling with the burden of regulation, while trying desperately to meet the needs of the rural elderly.

Mr. SCHUETTE. Thank you very much, Mr. Smith.

Our next panelist is Mr. Doug Pattullo, who is the chief executive officer of Tolfree Hospital, a 92-bed facility in West Branch, MI, not far from here.

Mr. Pattullo, I appreciate your coming here this morning. All statements provided today, and within the next 30 days, will be made a part of the record.

Doug, if you could take a couple of moments to express your view from the administration standpoint of a hospital, on the competing goals of the highest quality care at the most reasonable costs. And how it impacts on the health care needs of the rural elderly.

Please, and thank you for being here today.

STATEMENT OF DOUGLAS PATTULLO

Mr. PATTULLO. Thank you. I will try to do that in about 2 minutes.

I have an announcement to make, I really do not have much to say. I know everyone is hungry and ready to go, and we want to have some time for some questions.

I really do appreciate being invited to be here, today. My comments are going to be simply, to summarize, a few thoughts that I have and give a few recommendations, if I might.

First off, I think what has happened, is we see the entire health care system swinging, like a pendulum, from one way to another. Essentially, back in the days of Lyndon Johnson, there was a promise made to the elderly and the poor that they would get their health care funded by Federal dollars.

I think the discussion really is kind of masking the real point, which is that there is not enough money to go around.

Hospitals have been fraught with problems and complaints about increasing costs. I would quickly point out that our costs are increasing, but they are increasing mainly due to three factors.

They are increasing due to an increase in demand from the patient. They are increasing due to inflation. And they are increasing due to technology.

Lengths of stay in hospitals are decreasing, but they are decreasing for all ages, and all groups, not just the elderly. The decreases in the hospital stays have been caused mainly by advances in technology. Not many Medicare women have babies, but for an example, an OB patient 10 years ago might have stayed at my hospital 2 weeks. Now that person might stay 2 or 3 days. Again, the techniques have been developed to avoid the long stays in the hospital, which I think is fine.

Hospitals are very expensive. They are there for your very acute needs. What is happening now is that, yes, the people we admit are sicker, due to regulations, for example, from the Medicare Program. And hospitals deal with 20, 30, 40 different insurances, Medicare being only 1 of them.

We find that people are having problems getting admitted. They do not seem to meet the criteria established by Medicare for admission, be it an elevated count, or whatever the clinical condition might be.

Once the patients are admitted, the clock starts ticking for them. Actually good discharge planning from a hospital should begin upon admission. I know most of the hospitals in our district do have people that work in discharge planning, or an ombudsman's role, to try to help people make the connections they need to make to make that transition.

I think the difference is with DRG's. In the past, people used to stay at our hospital a few extra days, needed a less acute setting, perhaps convalescing a bit. Those were the nice soft days when the transition to the home or the nursing home was made. The family was contacted, and the patient was then discharged.

Unfortunately, insurance is not now paying for those days, after a certain point in time. There is no more money from the Federal Government to pay for the care in hospitals.

I think the answer is certainly to put some of that money into the aftercare and precare settings. As we heard from some of our other panelists, the money is being reduced from there, too.

I think that it is great to be able to live and to retire in rural America. I think rural American hospitals will still be there, and it is the backbone of the economy in most rural areas.

We do face a problem and a challenge in treating the elderly, as we do in treating all of the patients that we serve. I think that Dr. Harrison was right, after hearing him say that the burden, now, has been shifted onto the hospital and physician and patient from the Federal Government, and that is a little bit unfair.

I think as Joe said, it would appear that coordination and more money in various other settings might help in this transition. But it is very difficult for us in providing the care, and it is very difficult for those recipients of the care. We are all a little confused and a little frustrated by these changes in the Federal Government.

The signals had been, the elderly have a card to buy their care, based on the decision of the physician and the health care providers. Now those definitions have been changed and legislated into the DRG system. Unfortunately, the DRG system does not take into consideration the individual patient and their individual needs.

So, I would like to cut off here, if I might, and thank you for this opportunity.

Mr. SCHUETTE. Thank you very much, Mr. Pattullo, for being here.

If I may, I would like to address a question, both to Mr. Smith, and Doug. First, if I may, Mr. Smith, we talked a great deal this morning about the difficulties of early discharge—the premature discharge. And we have heard from the senior citizen activists, we have heard from patients themselves. Could you share with our committee today what types of efforts your hospital is making to communicate among the hospital patients and the local health services, and council on aging, in terms of monitoring and assessing a patient's discharge. How are the patients getting along at home, a nursing home, or what have you?

And second, does Gladwin Hospital, and others that you may be aware of, inform the patients of their rights to appeal?

Mr. SMITH. OK. Let me answer the first question. Patients are given several options for their after care. I heard earlier, one person commented that they were not sure who their patient representative, or patient advocate, was in the hospital. We would like to think everybody in Gladwin Hospital is a patient advocate.

Everybody has a responsibility to make sure that the patient, not only is cared for well in the hospital, but also after care.

On a formal basis, however, the Department of Social Services, which is in contact with all of the health departments and health agencies and places like that, provides a kind of a conduit between those agencies.

In addition, we have a registered nurse who acts as a utilization review person, who is not only responsible to make sure that the hospital and the physician meet the requirements of Medicare and the rest of the agencies, but also to talk to the patients, and find out what their particular needs are.

It is important to remember, though, that only the physician can discharge the patient. They are the ones that are responsible for discharging of patients, not the hospital, specifically.

And if the physician discharges the patient, we, at that point—or quite a bit before that point, try to work with the physician and the patient and the patient's family on the appropriate after care setting.

We are finding some difficulty, however, in finding the appropriate setting for those patients, as I indicated earlier.

I think that the other question, on the formal advocacy basis of informing patients of their rights, there are certain regulations that the hospitals have to meet, certain forms that are given to patients, that tell the patient exactly what their rights are. That they cannot be discharged without going through the appeal process. There are phone numbers for people to call to appeal. I think we follow those regulations in that regard.

Mr. SCHUETTE. Thank you, Mr. Smith.

Mr. Pattullo, my question is, How does Tolfree work with the patient, the physician, and the local council on aging to try to cope and assess what the early discharge—premature discharge problem is?

Mr. PATTULLO. Thank you, well, as Joe said, most hospitals hire people to work with the patients and their families regarding the insurance coverage and also making plans for the discharge.

In our shop, if you will, we have up to four people that do this type of work. They talk to the physician and talk to the family and talk to the patient. And then, based on what it is that the individual patient needs and the situation with the family, they try to make those necessary arrangements with DSS, or whomever. I think part of the problem in some of our areas is that some of those services simply are not available to the patient, and therefore, at times, it becomes very difficult.

This is very, very hard for us in a hospital setting because we have the patient and the patient's family, and with the physician, we want to make a placement—or get the patient ready to go. Just because the DRG says 5 days, the patient may not be ready to go home in that time. But the reality of it is that the Federal Government's Medicare Program says there is no money after that 5th day.

Yes, there are appeal rights, and we work with these families and the patients on appealing decisions that we do not feel are fair. But it is a very difficult problem.

Mr. SCHUETTE. Thank you very much, Mr. Pattullo.

I think at this point in time, I will yield to Congressman Tauke for some questions. And then I will wind this up in the not so distant future time.

Mr. TAUKE. Thank you very much, Mr. Chairman.

Let me focus my attention for a moment on you, Dr. Harrison, and the two hospital administrators. Now, as I listened this morning, it seemed to me I heard, what I would think would be, some fairly serious charges about the state of health care in this area, and some of the reports about early discharges and lack of care, lead me to believe that some of the people are fairly unhappy with the health care system in this area.

I did not hear much of a defense. Are all of these things isolated instances? Are they not true? Are you not concerned? I would like to hear your reaction to what you heard earlier.

Dr. HARRISON. I do not know what you mean specifically. If you are talking in terms of a patient advocate, I do know from personal experience we have three actually local hospitals that we send patients to. And they do, indeed, have an individual who does discharge planning with an emphasis on patient after care.

Mr. TAUKE. Doctor, does this mean—all these other people who were up here earlier, were they lying when they said they did not know that they had any rights when they were discharged? That they did not feel as if they had any kind of plan when they were discharged? They felt that they were discharged prematurely? I call some of these horror stories.

Are they wrong?

Dr. HARRISON. Congressman, I am one of those people who puts you guys in the Congress. You guys made the rule, and you guys have required that—OK, here it is, you go ahead and enforce it. I did not come in this business to be a policeman. I did not want to be a policeman. I am not a policeman. I am a very fine gentleman, but I am not a policeman. And I am not working to be your policeman.

Mr. TAUKE. So you are saying the same thing—these things did happen, but it is our fault.

Dr. HARRISON. They were not happening, in my experience. That they do, I certainly try to take a hand in it. They do what they can do. They have, to my knowledge, informed them of what their rights are, in terms of appeal.

Mr. TAUKE. You think there is an early discharge problem, or do you think that there is not an early discharge problem?

Dr. HARRISON. I think there is very definitely a discharge problem. And I am opposed to that. But like I said, I did not make the law.

Mr. TAUKE. I'm not trying to be difficult, although I am trying to get a little reaction from you, but——

Dr. HARRISON. Well, you got a reaction.

Mr. TAUKE. I am not sure, doctor, that I understand what you are saying to me, as you deal with people that feel they are doing a good job. They are trying to plan well, they are informing people of their rights. You are not aware of problems like those that we heard of this morning, yet you say there is a problem, I presume because of the regulations. Do you think the regulations are wrong, then, or that the policies——

Dr. HARRISON. I think the regulations are—like most regulations—are pointed at a mass of people. There is very little opportunity for individuals in this area.

Now, unfortunately, people when we are talking about people's rights—I do not know that the regulations take that into account. When people are 70, and when they get moved to an area such as this and do not have family up here, they are, essentially, isolated. They require more than in those areas where they might down in Detroit, where they have the support.

We have a large population who are basically retirees, who bought a home when they were younger and bought places where when they retired, they come up to fish, but then unfortunately they have accidents. And we have got a lot of them here alone.

Mr. TAUKE. Mr. Pattullo. Let me start with just a couple of factual questions. Do you now have a swing bed program?

Mr. PATTULLO. We do not. That is a real problem for us, Congressman. We have been urging Congress to move the number of beds from 50 to 100, to let a 100 bed and under hospitals swing those beds.

Mr. TAUKE. You do not even have them for 150 bed hospitals?

Mr. PATTULLO. No, we do not. We have not even had it passed in the State yet.

Mr. TAUKE. What is your occupancy rate?

Mr. PATTULLO. Hospitals in the State are running from 30 to 60 percent occupancy on the average. Our hospital currently runs about 60 percent.

Mr. TAUKE. And what is your Medicare patient percentage?

Mr. PATTULLO. Our hospital serves—55 percent of the patients that we serve are under the Medicare Program.

Mr. TAUKE. Mr. Smith, what is your Medicare percentage?

Mr. SMITH. About 59 percent right now. We run between 35 and 50 percent occupancy rate.

Mr. TAUKE. Now, you heard my questions to Dr. Harrison. It seems to me that you guys kind of took a beating this morning, too. What do you have to say in defense of yourselves?

Mr. SMITH. I guess one thing I can say is maybe it was better that I came in late. I would like to respond to that very briefly. There are hundreds of thousands of satisfied patients at these hospitals. There are instances, I am sure, where patients' care and the way their care has been handled may not meet their expectations.

I know for a fact that in our hospital, patients are not discharged unless they have an adequate form of care for followup after their hospital stay. However, that is not exactly what patients have been used to.

Patients have been used to spending the recovery period—the full recovery period in the hospital. Under PPS that full recovery period has to be spent in an alternative care setting, not in the hospital.

So, yes, I am sure that there are patients that feel that they are not getting—that they were not allowed to stay in the hospital long enough. I do note that hospitals are very, very careful. They have a tremendous responsibility too, to make sure the patients stay in the hospital if they need hospital care, and that they are not put out in the street, when there is no care available for them after they leave the hospital.

So, we are talking about individual situations. The numbers, I am sure, bear out that there is a problem. As I indicated earlier, there is a problem with arranging aftercare in an appropriate fashion.

Mr. PATTULLO. A couple of comments on that, Congressman. The hospitals and the physicians want, as bad as anyone, to have a good experience with the people that we serve. We are in a service industry and to a patient that feels that they were discharged early is a problem for us.

But we trade, as I said the second—in my particular institution, we see that we exceed the DRG days consistently, with certain diagnoses; our respirator care, our cardiac conditions, chronic lung conditions. I could tell you you could find a condition today under certain DRG's that I would lose money, point blank, and that patient will stay there many, many days over that DRG. We will not let that patient go.

Our positions, in the hospital, is very uncomfortable because the other side of that coin is that malpractice prices—you know, there are eight very distinctive acts of malpractice. The climate in Michigan for malpractice in medicine is horrible. Our officials have been working for years to try to get reform.

But the threat of malpractice is a tremendous burden over us, as is the fact that we are dealing with people in the hospital whose insurance is running out. So, think that it is our point of view that where we want the money, is in some of these aftercare services, and in home care, and what-not. Joe is right that people are used to staying in the hospital, and now, without paying for that, they will have to go somewhere. There is good care and good planning, nursing care, at home, because they will not be able to stay in the hospital when the DRG is exhausted. The Federal Government wants to save money by getting them out of our hospitals.

And they are repaying less for an alternative setting, an after care setting, and they are cutting their money, too, so I do not know how you can do it.

Mr. TAUKE. Well, this is my last question that, if I had had this hearing in Iowa, my hospital administrators from my district would have been in here saying that their very existence was threatened. At least some of them would have. Is your existence threatened, or are you making it?

Mr. SMITH. I do not think that—I do not like to portray a picture of gloom and doom. I think anybody that works hard in their business can stay in business.

Some of the legislation that Congress has passed is making it very difficult for us to stay in business. But we feel we have a responsibility to our community to stay in business. We are going to do our best to stay and to keep our rural hospitals alive and serving these communities.

Mr. PATTULLO. Congressman, the small hospitals are at risk right now. You mentioned that the hospitals make money on the DRG. In the State of Michigan, since 1983, Michigan hospitals lost $9 million to Medicare—in 3 years. Mainly because of the high cost of labor and the high cost of energy in the State.

Rural hospitals are a bit more at risk, particularly if they serve a great deal of elderly population. They are going to have to figure out how to pay for the care of the poor and the elderly.

Mr. TAUKE. Thank you, Mr. Chairman, for an excellent hearing.

Mr. SCHUETTE. Ladies and gentlemen, I am pretty close to wrapping this up. If I may, Mr. Pattullo, you mentioned a liability crisis. What I would like to do, by letter form, is ask these questions to the various members of the panel. And your response will be included in the record, if you do not mind.

Also, Mrs. Shurlow, and Dr. Hoelzel-Seipp, I have questions for you as well, if you would not mind if I handle it that way.

In addition, I feel that the mid-Michigan area is underserved. We need more doctors. We need more health care delivery systems. And Dr. Harrison and Dr. Hoelzel-Seipp, if I may address that question to you, and in a written form, I would appreciate your comments on how to attract more doctors to rural areas.

[The following material was subsequently received from the witnesses:]

**NORTHERN MICHIGAN
HEALTH SERVICES**

HOUGHTON LAKE CLINIC
HOUGHTON LAKE
NORTHPOINT CLINIC
ROSCOMMON
ST. HELEN MEDICAL CENTER
ST. HELEN

June 30, 1986

Congressman Bill Schuette
Attn: Alison Carberry
415 Cannon Building
Washington, DC 20515

Dear Congressman Schuette:

In reference to your letter of June 17, 1986, I am happy to comment on the subjects of medical liability and how we may encourage young physicians to practice in rural areas.

It is my observation that the current crop of young physicians are extremely well educated and able. These young practitioners appear well motivated toward their patients interests, however, I sense an increasing wariness in forming close interpersonal relationships both patient-to-physician and physician-to-patient. Most of our young practitioners have spent years of post-graduate training in institutional departments located in metropolitan areas. They feel a need for an institutional support system, which is in short supply in rural areas. It has been difficult for young practitioners to continue with their medical education in rural areas. An effort to bring continuing medical education to the local level(NAHEC)is currently underway and promises to be helpful.

Recently Munson Hospital and the Burns Clinic have become involved with a joint operation for helicopter evacuation of the critically injured. In addition the University Hospital system in Ann Arbor is offering a fixed wing plane program. These programs hold promise of less isolation, more cohesive and competent emergency medical service and better patient care, therefore appealing to the young practitioner and encouraging him/her to locate in a rural area. As more linkages to tertiary care facilities are made it is noted that this not only provides more comprehensive medical care for our patients, but also keeps the young practitioner in the main stream of current medical concepts.

I feel that young practitioners should be encouraged in personal community involvement through preventative services as well as the usual social familial activities with the church, schools, and so forth. This type of involvement pays dividends in better health care for the community.

Our experience with the National Health Service Corp has been good. These practitioners have been beneficial to the community and a satisfying number of them have elected to stay in this location following the repayment of their obligation to the NHSC. We trust that this trend will continue.

9249A West Lake City Road • P.O. Box 785 • Houghton Lake, MI 48629-0785 • (517) 422-5148

Congressman Bill Schuette
June 30, 1986
page 2

The medical liability situation as you are well aware is not new, however, the escalating economic impact has brought this situation to a head in Michigan. I am sure that there are greater intellects than mine at work on these problems who are working to provide legislative solutions. The real tragedy, as I see it, is that many fine young practitioners have elected to go elsewhere because of Michigan's unfavorable climate. Many very capable young men and women have elected not to offer their services in a high risk area where their expertise would be best utilized. This situation did not develop overnight and I am sure appropriate solutions are not going to be forthcoming overnight. Hopefully, the parties involved will continue to work together and a workable legislative solution will be found to this problem.

Thank you for allowing me to express my feelings in these matters. It is gratifying to know that problems in rural areas are being addressed by legislators such as yourself.

Sincerely,

Robert E. Harrison

Robert E. Harrison, M.D.
Medical Director

REH:ejk

PROBLEMS IN RURAL AREAS WITH MEDICAL MALPRACTICE LIABILITY AND PHYSICIAN AVAILABILITY

by: Joseph M. Smith, President
Gladwin Area Hospital

MEDICAL LIABILITY

The medical liability problem is acute and relief does not seem imminent. Rates for policies are increasing faster than reimbursement for services rendered. This problem is twofold:

1. Physician Liability Insurance
   As more and more physicians encounter problems gaining and retaining insurance coverage, there will be attrition from the ranks of hospital medical staffs. Larger hospitals with large staffs can usually withstand this attrition. Small hospitals won't have that luxury, and will be forced to subsidize malpractice insurance for their physicians, or provide coverage through a self-insurance program. This is a cost that is over and above normal hospital operating expenses, and will certainly increase the financial pressure on the organizations.

2. Hospital Liability Insurance
   Hospitals pay nearly two-thirds of all liability insurance premiums. Escalation in the costs and limited access to policies will increase the cost to all patients. When a rural hospital has a majority of patients that are covered by the prospective payment system, such increases in costs are not reimbursable. This single element of increased costs without increased reimbursement, will surely push marginal institutions into an unstable situation. Communities may lose their community hospitals.

There is no easy answer to this enormous problem. It is clear that the efforts to effect tort reform are being successful, but there is little hope that such efforts will eventually result in reduced malpractice costs.

Reducing malpractice insurance costs will depend on our ability to:

1. Reduce the attractiveness of filing claims that are without merit, or frivolous.

2. Eliminating or controlling the amount of damages awarded for noneconomic reasons.

3. Establishing reasonable compensation limits for attorneys who represent the plaintiffs in malpractice cases.

4. Eliminating the cause of malpractice. Only when strict and effective methods of removing dangerous physicians from the practice of medicine, will the malpractice crisis be relieved.

RECRUITING AND RETAINING PHYSICIANS IN RURAL AREAS

The American Medical Association is already predicting an excess of physicians, and is taking steps to, again limit the number of new doctors who graduate from medical schools. Rural areas will be the ones that suffer if such efforts are successful. Rural practices are not as lucrative as those in urban settings, which makes it difficult to recruit and retain quality physicians to areas with lower populations. An even greater problem is the fact that a rural practice may not be as professionally stimulating, because many of the more serious (and interesting) cases are transferred to larger metropolitan hospitals where facilities are more extensive.

How will rural areas maintain an effective group of practitioners so that health care is readily available in local communities? There are a few options that will help resolve the problem.

1. Provide incentives for medical schools to attract propective medical students who commit to practicing in underserved areas.

2. Provide incentives for reimbursement to rural hospitals who subsidize the practices of physicians, who are committed to rural health care.

3. Redesign the public health service districts to create more opportunities for physicians with PHS obligations.

JMS/cwp

Ladies and gentlemen, I think that this hearing today has been extremely informative, to Congressman Tauke, to us all.

We live in a rural district. We need better transportation for our senior citizens. We know their housing needs. Health care is an essential ingredient and we need to balance quality health care at a reasonable cost, but we cannot sacrifice quality.

We need to ensure that, particularly in remote, rural areas, that the delivery system to seniors contains services like Meals on Wheels. It is a partnership, ladies and gentlemen, between the health care provider, the Council on Aging, local officials, family members, and the Members of Congress—it really is a partnership in health care. And I think it is important that we, as citizens, continue to provide high-quality care at every level we can, to ensure that we have a better quality of life here in mid-Michigan.

Ladies and gentlemen, if you or your neighbors wish to submit something in writing, please do so to our office.

Panelists, before you leave, if I could say thank you. Your perspectives have been enlightening and helpful to Congressman Tauke and me.

And Tina Berry, you can serve your tuna fish now.

Thank you very much, ladies and gentleman.

[Whereupon, at 12:05 p.m., the hearing was adjourned.]

APPENDIX

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS

EXECUTIVE SUMMARY

The American Association of Retired Persons (AARP) believes that Medicare policies on rural hospitals should be based primarily on the needs of the rural elderly for access to cost efficient and quality health care.

While many rural hospitals are in poor financial condition, their problems can not be solely attributed to Medicare's prospective payment system (PPS). These hospitals are vulnerable due to their small size, low occupancy rates, and the weak farm economy. Indeed, the prospective payment system specifically protects the small subset of rural hospitals designated as sole community providers and regional referral centers.

HCFA has failed to provide Congress with essential data concerning the performance of rural hospitals under PPS.

The AARP believes further financial relief for rural hospitals at the expense of the Medicare program should be provided only where there is an objective showing that assisted hospitals are essential to continued access to care; that the hositals provide care that is comparable in quality to that which is available at the nearest alternative source of care; and that the rural hospital provides cost-effective services.

The AARP recommends that:

1. HCFA should quickly complete and publicly release mandated studies on rural hospitals under PPS;

2. the Medicare Quality Assurance Act (S. 2331) should be passed in order to enhance beneficiaries' rights and empower the PROs to review entire episodes of care and outpatient surgery;

3. the Part A deductible should be recalculated so that Medicare beneficiaries are not unfairly burdened with out of pocket costs. The high Part A deductible may serve to deny access to needed hospital care by the near-poor rural elderly;

4. existing Medicare conditions of participation should be retained for non-JCAH hospitals; and

5. HCFA should fund studies to evaluate rural hospitals in terms of their role in assuring access to cost-effective quality care in light of beneficiary health care needs. Data from these studies should guide Medicare policies on rural hospitals.

Introduction

Our acute care health delivery system is characterized by excess capacity and maldistribution of resources. AARP's basic health policy goals are to control health care costs while maintaining access to quality care. We strongly believe these goals should be the basis for Medicare policies with respect to rural hospitals. We start from the premise that the needs of consumers are more important than the needs of hospital administrators. Any decisions regarding the survival of a particular hospital or a category of hospitals should be made with reference to the impact on consumers of closure, conversion, or maintenance of a hospital.

Rural Elderly

The health care needs of the rural elderly are of central importance to any discussion of rural hospitals.

According to the 1980 census, about 11% of the rural population consists of persons aged 65 and older. Rural hospitals are heavily dependent upon the elderly as a source of patients. Otherwise put, total Medicare admissions to rural hospitals have long comprised a higher percentage of total admissions than they have for urban hospitals. In 1984, 40% of rural hospital admissions were for Medicare patients compared with 34% for urban hospitals (1986 Annual Report of the Prospective Payment Assessment Commission, (PROPAC), April 1, 1986). Rural hospitals' dependence on elderly patients increased between 1980 and 1984.

Rural hospitals have also been more dependent than urban hospitals on Medicare patients when measured as a percentage of total patient days. In 1984, 46% of days of care in rural hospitals were paid for by Medicare, compared with 43% of urban hospital days of care. Because rural hospitals depend so heavily on Medicare as a revenue source, changes in reimbursement methods, fee schedules, and utilization by the elderly disproportionately affect the viability of rural hospitals. Seventy-three percent of rural hospitals in 1984 had 100 beds or less. Small hospitals are especially vulnerable to slight changes in revenue and occupancy and cannot easily absorb losses.

That is, small hospitals have fewer available coping mechanisms with which to respond to market changes.

Rural Hospitals in Jeopardy

Administrators of rural hospitals have, since 1984, requested additional financial assistance from the Medicare program on the grounds that the prospective payment system and declining Medicare admissions rates threaten their financial stability and could result in their closure.

While there is considerable evidence that rural hospitals are financially vulnerable, it is much less clear that Medicare is to blame.

Studies show that small hospitals with lower occupancy rates are more likely to close than others. This propensity to close was found to hold true between 1960 and 1980 (see for example, L. Kennedy and B. Dumas, "Hospital Closures and Survivals", Health Services Research 18:4, Winter 1983). But, the American Hospital Association found that 57% of the community hospitals that closed in 1985 were in large metropolitan areas. (Hospitals , April 5, 1986, p. 93).

Even before prospective payment was instituted, rural hospitals were in trouble. Their average length of stay for elderly patients was lower and they had lower occupancy rates (61%) in 1980 than did urban hospitals (72% occupancy) (PROPAC Annual Report). Furthermore, small (less than 100 beds) rural hospitals had worse operating margins between 1980 and 1982 than did other hospitals.

Fiscal distress due to declining occupancy in rural hospitals is partly traceable to the 1982-83 farm crisis. For example, during that period, rural hospitals in Kansas experienced a 37.4% occupancy rate. And, the American Hospital Association reported that in 1983, overall declines in admission were greater for those under age 65 and attributed lower admissions to bad weather, a poor economy, unemployment, and Medicaid cutbacks (Hospitals, June 1, 1984, p. 20).

All of this points to a conclusion that the fiscal crisis confronting rural hospitals can not be laid only at Medicare's doorstep. But, all the indicators of fiscal health clearly show that rural hospitals are in a much weaker condition than are urban hospitals, partly because rural hospitals tend to be smaller and to have overall lower occupancy rates.

PPS Effects

Rural hospitals report a sharp decline in admissions since 1983. Between 1983 and 1984, rural hospitals experienced a 5.7% decline in occupancy compared with a 2% decline for urban hospitals. And, between January 1984 and June 1985, small (less than 50 beds) hospitals had a 15.7% decline in admissions.

But, rural hospitals in general improved their operating margins between 1983 and 1984 and ended the year with the best operating margin reported since 1980.

One way many rural hospitals have learned to cope with declining inpatient census is to diversify their services and provide them on an outpatient basis. In 1985, 15% of rural hospitals increased the use of outpatient services. In 1984, even hospitals with less than 50 beds performed over 70,000 ambulatory surgical procedures. Hospitals with fewer than 100 beds account for nearly a third of all rural ambulatory surgery. (1984 Annual Survey of Hospitals, American Hospital Association). We at AARP are concerned about the trend toward outpatient hospital services because of the high Medicare beneficiary co-payments required and because PROs do not scrutinize outpatient hospital services for quality and necessity. We are especially concerned about the surgical procedures done at very small hospitals and want to know more about the types of surgery being done and the resulting mortality and morbidity rates for these procedures. Hospital-based outpatient cataract surgery (a common Medicare procedure) has both a higher total cost and higher cost to the beneficiary than does the same procedure when performed on an inpatient basis. Policy makers and beneficiaries alike need to know more about the effects of outpatient services on the cost and quality of care provided by rural hospitals.

Furthermore, many rural hospitals are benefitting from special protections under the PPS system. The protections are afforded to rural hospitals classified as "sole community providers" and "referral centers". These special protections are intended to preserve access to care.

Several Congressionally mandated studies of the effects of PPS on rural hospitals in general, as well as on sole community providers and referral centers in particular, have been completed but withheld by the Health Care Financing Administration (HCFA).

These studies may provide valuable data with which to evaluate how rural hospitals are faring. It makes little sense to withhold these studies or to devise new payment policies absent data. We urge HCFA to release these studies immediately so that we can factor their findings into policy debates.

Types of Rural Hospitals

Rural hospitals are not homogeneous. HCFA defines a rural hospital as a facility located outside of a county in which there is a population center with 50,000 people. Some rural hospitals may be quite near one or more other hospitals with which they compete. Others may be in a sparsely populated county but adjacent to an urban area in another county. Rural doesn't always mean isolated.

In fact, a survey of rural residents found that 30% prefer to travel for medical care. (Modern Healthcare, December 6, 1985, p. 82). The point is that not all rural hospitals are essential to maintain access to care.

The vital role of maintaining access is performed by a special subset of hospitals - both urban and rural - designated as sole community providers and/or referral centers.

Only 345 (or 12.8%) of the nation's 2,705 rural hospitals are sole community providers. One hundred and forty hospitals (5.2% of the total) are referral centers. Fourteen hospitals carry both designations.

By definition any hospital fifty miles from another short stay acute hospital is eligible for sole community provider status. In addition, hospitals can receive this designation even if they are less than fifty miles from the nearest hospital if weather or topography often make it difficult to reach another hospital.

Sole community providers remain at 75% hospital specific payment rates under PPS. This permits hospitals with higher costs to receive higher payments under PPS.

In addition, when sole community providers experience a decrease in total discharges that is 5% higher than the previous cost reporting system, they can receive increased PPS payment if the decline is due to extraordinary circumstances beyond the hospital's control (42 C.F.R. 412.92).

There are several unanswered questions about this aspect of PPS. One study found that only 80% of eligible hospitals have received sole community provider designation (D. Farley, "Sole

Community Hospitals", DHHS publication No. (PHS) 85-3348, March 1985, p. 17). We don't know how many potentially eligible sole community providers have not sought this designation because their expenses are the same as or less than the national rate. These hospitals will benefit from the move to a national rate.

Furthermore, few hospitals have availed themselves of the opportunity to be compensated for declining patient discharges. Thus far, HCPA has dealt with only four hospital requests for compensation (two approved, 1 denied, and 1 returned for more information). Four more applications are pending. Again, HCPA does not know why so few requests have been filed.

Based on one government study, (Farley, Ibid.) we can make the following generalizations about sole community providers:

o Their patients have shorter lengths of stay than those at other rural hospitals. The same is true of their Medicare patients;

o Medicare patients constitute a smaller percent of their total admissions than for other rural hospitals;

o They have a much lower occupancy rate (47%);

o Their labor costs, adjusted for case mix, are lower and they employ fewer full time staff;

o They serve a younger, predominately white, and healthier population than that served by other rural hospitals. Mortality and morbidity rates for their population are generally lower than for those served by similar rural hospitals. They treat less severe case mixes than other rural hospitals.

By definition, referral centers are located in a rural area, have at least 500 beds, and half of their Medicare patients are referred from another hospital or from physicians not on staff. In addition, 60% of the Medicare patients treated must live more than 25 miles away and 60% of the hospital's services to Medicare beneficiaries are provided to those who live 25 miles away. Once designated, referral centers are paid on an urban rate adjusted by the hospital's area usage index.

Access

As noted above, Medicare already includes some financial protections for hospitals that serve a vital role in providing access to care for isolated communities.

There is no evidence to sustain a claim that every rural hospital is essential for access to care. In fact, rural hospitals often serve less than half of the local residents; the rest prefer to go elsewhere for care (Modern Healthcare, September, 1984).

We simply don't know enough about the services provided by rural hospitals in relationship to residents' needs. For example, we need to know about available transportation to alternate sources of care. The 1980 Census found that 20% of rural older householders do not have a car. Twenty-six percent of older rural households living in areas populated by 1,000 to 2,500 residents have no car. We certainly need to assure access to care for these people. But, 80% of older households do have private transportation and it might be in their interest to travel further if the care provided is superior to that which is locally available.

We also need to compare the reasons for Medicare admissions with the capabilities of rural hospitals. How well do these hospitals treat emergency cases? Would consumers be better off going elsewhere for elective procedures? We simply don't know. Many advocates of rural hospitals argue that they are essential to the continued availability of physicians. They claim that local doctors would leave the area if the hospital closed. We know of no evidence to support that claim. HCFA should be studying these questions.

Since the proportion of elderly poor and near poor persons is higher in non-metropolitan areas than it is elsewhere, we are concerned that the rapidly rising Part A deductible could effectively deter rural elderly people from seeking needed hospital care. According to the U.S. Census Bureau, 27% of older Americans living in non-metropolitan areas in 1983 had incomes below 125% of the poverty line. We need to know whether the Part A deductible had a disproportionately negative effect on access to care for these Medicare beneficiaries.

Quality

While there are no published studies of the quality of care provided by rural hospitals, there are some disturbing signs that small rural hospitals may not be up to snuff. One-third of rural hospital administrators surveyed said that the quality of care given to Medicare patients worsened since the introduction of prospective payment. (Modern Healthcare, December 6, 1985, p. 86).

An eight-state survey of lab technicians found that 23% of lab personnel in hospitals with less than 100 beds are not certified. Forty percent of the non-certified lab technicians working in the smallest hospitals have only a high school diploma and need basic training in their job. (Modern Healthcare , September, 1984, p. 178).

We are also deeply concerned about the problem of premature discharges of Medicare beneficiaries in rural hospitals. While the Inspector General's report on "Inappropriate Discharges and Transfers" dated March 1986 does not indicate the proportion of questionable discharges attributable to rural hospitals, discharges in rural areas may raise greater problems for beneficiaries and their family. First of all, small rural hospitals are less likely to have a department of social work staffed with qualified discharge planners. In 1982, only 51% of rural hospitals offered social work services compared with 78% of other community hospitals (Farley, Op. Cit, p. 9). Secondly, home health care agencies are less available in rural than urban areas. We fear that Medicare patients may be discharged from rural hospitals quicker and sicker into a no care zone.

We are further alarmed by HCFA's persistent intention to issue new and substantially weaker Medicare conditions of participation for non-JCAH accredited hospitals. In 1982, only 58% of rural hospitals had been accredited by JCAH, compared to 80% of other community hospitals. (Farley, Op. Cit., p. 6). AARP is a member of a coalition seeking to maintain the existing stronger conditions of participation because we are convinced that the proposed new conditions will weaken quality standards, jeopardize consumers, and send the wrong signal to the hospital industry. It is outrageous that the Department of Health and Human Services has basically ignored more than 36,000 comments from 85 professional medical and consumer groups submitted in response to the proposed new conditions of participation. The preponderance of these comments were negative, yet the Department has been largely unresponsive to the sincere quality and safety concerns of those who oppose the issuance of these new and weaker regulations.

Furthermore, since HCFA has failed to issue Congressionally mandated studies on the performance of rural hospitals under PPS, it seems unreasonable to revise Medicare regulations absent reliable data on their cost and quality consequences.

AARP Recommendations

AARP believes that rural hospitals should be evaluated on the basis of their role in maintaining access to care and on their demonstrated ability to deliver cost-efficient quality care.

Consumers need objective and current information about the cost and quality of care offered by nearby rural hospitals in comparison with care provided by alternate sources of care. In light of the foregoing considerations, AARP makes the following recommendations:

1. AARP concurs with PROPAC's recommendation #11 that HCFA should quickly complete and issue its mandated studies of rural hospitals under PPS (p. 38). We also agree that data from these studies are an essential prerequisite to considering changes in the payment system.

2. AARP concurs with PROPAC's recommendations #15-19 concerning beneficiaries' rights, PRO review of episodes of care and outpatient surgery as well as recalculating the Part A deductible. Consequently, AARP urges the rapid passage of the Medicare Quality Assurance Act (S. 2331) as an excellent means to implement these PROPAC recommendations.

3. Existing Medicare conditions of participation for non-JCAH hospitals should be retained.

4. HCFA should fund studies to evaluate rural hospitals in terms of their role in assuring access to cost-effective quality care in light of beneficiary health care needs. Data generated by these studies should be used to evauate requests by hospital administrators for additional Medicare payments.

PREPARED STATEMENTS BY THE AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

PREPARED STATEMENT OF ROBERT V. STUTZ, ALBERT EINSTEIN MEDICAL CENTER, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION, BEFORE THE HOUSE SELECT COMMITTEE ON AGING, APRIL 10, 1986

Mr. Chairman, I am Robert V. Stutz, Vice President of the Albert Einstein Medical Center, Philadelphia, Pennsylvania. I am here on behalf of the American Hospital Association, which represents 6,300 hospitals and health care institutions. I am the general director of the Willowcrest-Bamberger Division, our short-stay, hospital-based skilled nursing facility.

I would like to address my comments to two areas. First, I will discuss the problems affecting my institution in particular as an example of the difficulties facing health care institutions in general, and, secondly, the impact of the Medicare budget crisis. I commend Representative Roybal and members of the committee for their sensitivity to issues affecting the elderly in the new health care system of the eighties. I want to assure you that there need not be a "no care" zone. Our experience with reductions in post-hospital care began a year and a half year ago, just prior to implementation of the prospective payment system. With the new system, HCFA certainly recognized that post-hospital care would become a more important element in the continuum of care. However, it appears that HCFA has chosen a course of action that would drastically restrict access to skilled nursing facility post-hospital care.

Through HCFA directives, two unprecedented actions have been undertaken. The first was the implementation of 100 percent chart review by fiscal intermediaries of all patients transferred from the acute care setting to a hospital-based skilled nursing facility. HCFA claims that this action was taken to assure that patients were not prematurely discharged from the acute care setting. In reality, this review has been used as an adversarial tactic to deny patients thousands of skilled care days under the pretext of a new, stringent HCFA interpretation of Medicare criteria. The rate of denied days grew from zero to over 76 percent in late 1984 and into 1985 at our 102-bed skilled nursing facility. This translates into a financial loss of over $1 million in Fiscal Year 1985, and a closing of 50 post-hospital skilled nursing beds. But more importantly, access to needed care was denied to hundreds of patients who we felt met Medicare criteria and in the past were eligible for skilled care. The second method used by HCFA to discourage use of post-hospital Medicare services has been to eliminate the waiver of liability. We anticipate that the waiver will be restored shortly, but we would ask the Committee's diligent oversight to ensure that HCFA does not issue directives that will thwart the intent of presumptive status.

The bottom line is that thousands of patients who could benefit from a less costly post-hospital stay are denied their benefits. This benefit is fraught with inconsistent interpretation. The outcome of a case review varies with each HCFA region and intermediary. Providers and beneficiaries are given no specific reason when coverage is denied. This policy helps compound inconsistencies in interpretation and makes it difficult to determine who is eligible for admission to a skilled nursing facility.

Let me take a moment to describe some interpretation problems that we are experiencing in our facility in interpreting HCFA policy.

In our region, HCFA has determined that "transferring," a very important physical therapy service, is no long considered skilled care. Transferring is teaching a patient how to get from a bed into a chair. This skill alone makes the difference between living in a long-term care setting or returning to one's home and community. HCFA has decided that the teaching of transferring is not justifiable physical therapy. Even when there are other complicating medical factors that are reimbursable, the physical therapy portion of the skilled stay will be denied.

A second service we have traditionally provided has been to admit debilitated patients undergoing a course of radiation therapy in our adjacent hospital. Medicare has refused payment for frail elderly cancer patients who are undergoing radiation therapy. The Adminstration decided that this service should be provided on an outpatient basis. The result is that these patients must take exhausting and life-threatening ambulance rides twice daily. We are also told that the Medicare skilled benefit is to be applied with absolutely no regard to social circumstances or support services available in the patient's home.

I would like to offer a basis for improving access to post-hospital care. First, the Medicare skilled nursing criteria need to be rewritten so that they are consistent with the prospective payment system. Criteria should be specific and administered consistently. Perhaps peer review organizations (PROs) could provide continuity and consistency of judgment as patients move between the acute care hospital and the skilled nursing facility.

Second, in an effort to increase the number of providers that would offer short-term, post-hospital care, patients should be pre-certified by the PRO. This minimum pre-certification period could allow the patient and the provider a guaranteed, secure benefit.

I would also recommend a change in the appeals process. Providers must be allowed to use the appeals process without the involvement of the beneficiary. This is necessary since it is only the provider who is at financial risk after admission. Furthermore, many elderly beneficiaries are medically unable to assist in the lengthy appeals process. In addition, court ruling should be deemed precedential.

A recent patient placement survey performed by the Delaware Valley Hospital Council, located in Philadelphia, documents continued problems hospitals are experiencing in placing patients in facilities providing subacute, skilled care. This survey estimated a loss exceeding $23 million to Southeastern Pennsylvania hospitals providing skilled, subacute care to patients awaiting transfer to post-hospital care facilities. In addition, this money could be better spent on behalf of Medicare beneficiaries.

MEDICARE BUDGET CUTS

Since 1981, the Medicare program has been cut by $40 billion. This constitutes 12 percent of all budget cuts even though the Medicare program represents only 7 percent of federal outlays. The President's Fiscal Year 1987 budget called for a Medicare reduction of $5.2 billion and Medicaid cuts of $1.2 billion. Since 1981, defense spending has increased from 22 percent to 26.5 percent of federal outlays while Medicare has declined from 7.6 percent to 7.1 percent of outlays. We believe that health programs should be treated equitably relative to other budget categories.

In addition, if Congress and the President are unable to agree on a plan to reduce the deficit to the $144-billion level required by the Gramm/Rudman/Hollings law, Medicare payments to hospitals will be reduced automatically by

2 percent effective October 1, 1986. This would amount to a reduction of 3 percent below the FY 1985 level of payment.

QUALITY OF CARE UNDER THE PROSPECTIVE PAYMENT SYSTEM

The major restructuring of the Medicare program under prospective payment has resulted in substantial changes in the health care system. With the establishment of this new approach to more cost-effective health care, attention now must focus on maintaining quality of care.

A recent study prepared by the Hospital Research Foundation of the Hospital Association of Pennsylvania examined utilization patterns in Pennsylvania hospitals over a three-year period. The study is based on an analysis of 4.5 million discharges from the state's community hospitals between July 1982 and June 1985. It compares the two years preceding PPS to the state's first year under the system. The study found that changes in hospital utilization patterns are for all patients, not just for Medicare patients. The average length of stay dropped from 7.7 days in 1983 to 6.6 days in 1985, a decrease of 14.3 percent. Medicare patients exhibited the most significant decline in length of stay, from 11.1 to 8.8 days, a 20.7 percent decrease. Readmissions decreased 23 percent, from 203.5 per 1,000 discharges in 1983 to 156.4 per 1,000 in 1985, though readmissions within 14 days were up. The increase in readmissions applied to all payers.

In addition, the study found that the average length of a hospital stay decreased for all patient payment categories. Transfers from the original transferring hospital to another type of provider increased. Patient acuity levels differed among transfer sites. Five transfer sites (organized home care, psychiatric facilities, intermediate care facilities, custodial care and others) experienced increases in the number of transfers during the three-year period.

CONCLUSION

The implementation of Medicare's prospective payment system has provided a unique opportunity for examining the objectives of cost-containment, quality of care, and access to services. If the system is manipulated simply to produce short-term budget savings, the result wil be a reduced ability by hospitals to provide services to the elderly. A successful Medicare system requires payments that are adequate and equitable. Only then will the program be able to meet its objective of containing costs without adversely affecting the delivery of high-quality services to the Medicare population.

PREPARED STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION, BEFORE THE SUBCOMMITTEE ON HEALTH, COMMITTEE ON FINANCE, U.S. SENATE, MAY 9, 1986

SUMMARY

The American Hospital Association (AHA), which has created a Special Committee on Small or Rural Hospital Care to study equity issues concerning small or rural hospitals' participation in the Medicare prospective pricing system, shares this Subcommittee's concern about the condition of rural hospitals in the United States. The 2,696 rural hospitals in the nation comprised nearly half of total U.S. general hospitals in 1984, the latest year for which AHA annual survey data are available. The implementation of the Medicare prospective pricing system has had a tremendous impact on these institutions, for which changes in utilization and costs seem to have outstripped increases in payments.

Expansion of rural referral center criteria and adoption of a new area wage index offer some relief, but numerous problems remain: inadequacy of the DRG payment system, in terms of volume fluctuations, discrepancy between urban and rural rates, and updating factor; outlier policy; and access to post-acute services. Despite special treatment, sole community provider hospitals remain at risk, with a return to cost-based reimbursement needed to recognize changes in costs related to case mix, admissions declines, and modifications in community demand. As solutions are applied to these problems, they must recognize the burdens of administrative paperwork and cash flow for small, rural hospitals.

INTRODUCTION

Mr. Chairman and members of the Subcommittee, I am Gordon H. Russell, administrator of Hi-Plains Hospital, Hale Center, Texas. Hi-Plains Hospital is a not-for-profit institution that is located in a predominately agricultural community. It has 84 licensed beds, 40 for short-term acute care and 44 for long-term care. The hospital, which was an early participant in the "swing-bed" program, also operates a home health agency.

I appreciate this opportunity to testify on behalf of the American Hospital Association's 5,600 member institutions and 40,000 personal members. For six years, I served on the governing council of the AHA's Section for Small or Rural Hospitals, and, for one year, chaired the council. At the request of the section, the General Council of the AHA last October created a Special Committee on Small or Rural Hospital Care to study both the equity concerns of small or rural hospitals with respect to the Medicare prospective pricing system and other financial constraints that inhibit such hospitals' ability to provide needed health care services to their communities.

Complementing the work of this targeted panel are two broader AHA efforts: an investigation of the impact of the DRG-based prospective pricing system on all types of hospitals, including rural, and development of alternatives, such as a capitated model, to the DRG system.

Concerned about the adequacy and equity of payment under the existing prospective pricing system, the AHA is pleased that the Subcommittee is holding this hearing today to examine the condition of rural hospitals under the Medicare program, and commends the esteemed chairman, Senator Durenberger, and the distinguished ranking minority member, Senator Baucus, for seeking this forum.

In this statement, following a brief statistical overview of rural hospitals, I will look at two adjustments affecting such hospitals that already have been made in the prospective pricing system: in the definition of rural referral centers and in the adoption of a new "gross area wage index." I then will discuss problems that need to be resolved: in terms of the appropriateness of DRG payment, volume considerations, urban and rural rates, and the uniform rate of increase; outlier policy; and access to post-acute services, including swing-bed utilization. In addition, I will examine special treatment for hospitals that are the sole providers of care in their communities. In exploring these topics, my overriding concern is the preservation of access to quality health care in rural communities.

STATISTICAL OVERVIEW

Of 5,969 general hospitals in the United States, there were 2,696 rural hospitals (or 47 percent of the total) in 1984, the latest year for which AHA "Annual Survey of Hospitals" data are available. More than two-thirds of the hospitals had fewer than 100 beds: 182 had fewer than 25 beds; 799, from 25 to 49 beds; and 932, from 50 to 99 beds. Of the remaining, 606 had from 100 to 199 beds, and 177, 200 beds and over. Many of the hospitals with more than 200 beds serve as rural referral centers (although not all qualify for the Department of Health and Human Services [HHS] designation); as such, they offer an extensive range of services.

In the results from the same survey, 3,670 U.S. hospitals were designated as small or rural: having fewer than 100 acute-care beds, experiencing 4,000 or fewer annual admissions, or being located outside a Metropolitan Statistical Area (MSA). Of the total, 73 percent were classified as rural and 27 percent as small urban. In 1984, such hospitals accounted for more than 50 percent of total hospitals and for between 26 percent and 50 percent of total beds in eight of the nine U.S. Bureau of the Census divisions, with Region 2 the exception:

Census Divisions	Percent of Small & Rural Hospitals	Percent of Small & Rural Hosp. Beds
Region 1 (CT, ME, MA, NH, RI, VT)	51%	26%
Region 2 (NJ, NY, PA)	33%	14%
Region 3 (DE, DC, FL, GA, MD, NC, SC, VA, WV)	59%	31%
Region 4 (IL, IN, MI, OH, WI)	55%	26%
Region 5 (AL, KY, MS, TN)	77%	48%
Region 6 (IA, KS, MN, MO, NE, ND, SD)	84%	50%
Region 7 (AR, LA, OK, TX)	74%	37%
Region 8 (AZ, CO, ID, MT, NV, NM, UT, WY)	79%	43%
Region 9 (AK, CA, HI, OR, WA)	58%	28%

Additional data show that 49 community hospitals closed in 1985, 39 of which had fewer than 100 beds. Only 1 of the 49 had more than 300 beds. The hospitals were in 23 states, with the greatest number in California and Texas, with eight each, followed by New York with six and Michigan, four. In contrast, from 1980 through 1984, the yearly average of closures was 33.

IMPLEMENTATION AND ALTERATIONS OF MEDICARE PROSPECTIVE PRICING

The Medicare prospective pricing system was implemented October 1, 1983, less than six months after the Social Security Amendments of 1983 were signed into law. The system is an enormous, and generally positive, step toward a payment system that encourages the efficient delivery of effective medical care. Because the changes embodied in the system are so large and complex, and were put in place so swiftly, implementation of the system has not been without problems for rural hospitals. Many of these problems also have been encountered by urban hospitals, although with different results because of their environments.

Some Effects

Various effects have already been examined by this Subcommittee, in hearings on hospital operating margins, deficit reduction proposals, an adjustment for hospitals with disproportionate shares of low-income patients, direct medical education, Peer Review Organizations (PROs), and prospective pricing implementation issues. As already reported, the most dramatic effect has been substantial change in hospital utilization. Hospitals report that their admissions have declined and that the complexity and severity of illness of patients they have admitted have increased significantly.

To some degree, these changes may result in higher payments if the DRG mix of a hospital increases. However, the ability of DRGs to reflect the cost of resources used in caring for patients admitted to hospitals is limited by the DRG classification methodology. Particularly in small or rural hospitals, changes in utilization and costs appear to have outstripped increases in payments. Although figures for Medicare alone are not available, overall average per-case costs in hospitals operating fewer than 50 beds rose by 14.6 percent in 1985. Because this change reflects both Medicare and non-Medicare patients, the result is a substantial deterioration in the financial position of smaller hospitals--a prediction consistent with hospital operating margin figures reported February 21 to this Subcommittee.

Two Changes

At the time Medicare prospective pricing was implemented, it was clear that refinements in the rules would be required to improve the adequacy and equity of payments to hospitals under the program and to minimize disruption of services to Medicare beneficiaries. In a program legislated and regulated so significantly, it was obvious from the onset that "tinkering" would be needed.

Rural Referral Centers

The Deficit Reduction Act of 1984 called for various refinements, including revised criteria under which a hospital could qualify as a regional referral center. Previously, a hospital could receive the referral center designation if it met very exclusive standards: bed size of at least 500 and location in a rural area or satisfaction of restrictive patient origin criteria.

The Deficit Reduction Act expanded the concept. It required a hospital to meet two mandatory criteria: having a proscribed case mix index (1.03 in 1981 or 1.09 in its first prospective pricing cost reporting period, since updated) and number of discharges (at least 6,000). It also provided for a hospital to fulfill one of three optional criteria: more than 50 percent of its medical staff composed of "specialists," at least 50 percent of its discharges for inpatients that reside more than 25 miles away, and at least 40 percent of its inpatient referrals from non-staff physicians.

Although the expanded criteria are substantial improvements, they still exclude some hospitals in rural areas that serve as referral centers. The criteria are, like the prospective pricing system, based on averages that identify hospitals whose range of services and case severity are generally higher than average for their peer group. In the short term, HHS should regard the criteria as benchmarks rather than absolutes, not only because of their inadequacy but also because of the occurrence of minor fluctuations in case mix or admissions that can shift a hospital back and forth across the limits, even though its status and higher per-case costs do not vary. In the long term, HHS should develop service-specific criteria for such centers (as well as for urban referral centers) and pay for the services they offer on the basis of hospital-specific prices. Ultimately, the solution to this problem is the development of more adequate DRGs that reduce the need for separate urban and rural rates.

Area Wage Index

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 requires the HHS Secretary to implement--for hospital discharges occurring on or after May 1, 1986--a new "gross wage index" included in Medicare prospective pricing regulations published September 3, 1985. The AHA has supported adoption of the new index, due to the inadequacy of the one used to adjust federal prices under prospective pricing since implementation of the system.

The old index did not account adequately for the effects of regional variations in the mix of full- and part-time employees. It also did not recognize deficiencies in MSA and non-MSA designations to define labor markets. The new index addresses the first, but not the second, problem, which necessitates a reexamination of the adequacy of MSAs and states to define labor markets. Congress recognized this need in part when it included in the COBRA provision the requirement that the HHS Secretary work with the Prospective Payment Assessment Commission (ProPAC) in studying and developing methods of adjusting wage indices to reflect hospital labor markets more accurately. Although the provision specifically targets inner-city portions of urban areas--an essential focus--expanded study is needed as well, as pointed out by ProPAC in its April 1, 1986 "Report and Recommendations to the Secretary, U.S. Department of Health and Human Services." In urging the HHS Secretary to "improve the definition of hospital labor market areas for Fiscal Year 1987," the commission states: "For rural areas, the improved definitions should account for a greater amount of the wage variation between different rural areas within each state and between states."

The AHA has been conducting analyses that document the inadequacy of the MSA-based definition and demonstrate the availability of alternative methods of defining hospital labor markets.

PROSPECTIVE PRICING SYSTEM LIMITATIONS

Although some of the changes made in prospective pricing since its inception have helped to correct some of the system's flaws, significant problems remain. The first involves application of the existing DRG system to rural hospitals.

Recently, some rural hospitals have questioned the appropriateness of DRG-based payment for hospitals serving small, rural communities. Nationally, the smallest hospitals have reported substantial losses, often related to sharp reductions in utilization. These hospitals are often the only health care facilities in their communities and are critical to the continued availablity of medical care. The questions they pose center on volume fluctuations, discrepancy between urban and rural rates, and a uniform updating factor for all types of facilities.

Volume Considerations

The DRG payment system is based on averages. For the system to work, it is necessary for a hospital to have a volume that is sufficiently large so that both its Medicare revenues and per-case costs are stable from one period to the next. While many hospitals appear to have case mixes that are reasonably stable, some hospitals are experiencing significant fluctuations in them. In small hospitals, such fluctuations are not necessarily reflected in per-case costs, although they do result in shifts in revenues.

In order for these hospitals to meet the daily costs of operation, given these fluctuations in cash flow, it is necessary for them to resort to borrowing or slowing down payment to vendors, both of which unnecessarily increase costs. It is not that these hospitals are too small to survive, but rather that the flow of expenses does not match the flow of revenues.

Urban and Rural Rates

The topic that has caused the most discussion has been the difference between urban and rural rates of payment. Because the difference in prices is based on a difference in average costs in urban and rural hospitals, it is paradoxically both reasonable and unfair. It is reasonable to the extent that it is due to significant differences in case mix that are not measured by DRGs. It is unfair to the extent that it results in arbitrary differences in payment for the treatment of similar patients. Larger rural hospitals treat many of the same types of patients treated in the average urban hospital. The costs incurred in treating these patients in rural and urban hospitals are often comparable. But the level of payment is based on the location of the hospital, not the characteristics of the patient. The real question is not whether the differential should exist, but what to do about it. In the long run, the differential should be eliminated. It can be eliminated, however, only if the defects in the system of DRGs can be eliminated or an alternative method of setting prices that is sensitive to those defects can be identified.

A difference in payment based on location is bound to be inequitable to some degree. Ideally, the payment system would establish a single payment schedule applied to all hospitals, with adjustments as appropriate only to reflect differences in wages and other input prices. Such a system is feasible, however, only if prices are based on accurate measures of case mix, costs, and input prices.

The magnitude of the cost differences between urban and rural hospitals, as well as the difference in costs between other groups of hospitals, suggests that these conditions are not being met. Although it would be inadvisable to move to a single uniform rate without correcting the problems that led to the adoption of separate urban and rural rates, it is also necessary to address the inequities created by a dual rate system.

Uniform Rate of Increase

One special problem posed by the difference between urban and rural rates that has received relatively little attention concerns the appropriateness of using a uniform rate of increase to update urban and rural prices for the effects of inflation, technology, and product changes. The price differential was based on the difference in average costs in 1982. In the three years since 1982, utilization patterns have changed dramatically. As noted earlier, small hospitals have experienced a particularly sharp decline in admissions, and this decline has been accompanied by an above-average rate of increase in per-case costs.

Anecdotally, rural hospitals have reported that one effect of PRO review has been to increase the acuity of patients who are admitted to hospitals. If true, then it is possible that the difference between urban and rural costs is declining. Applying a uniform rate of increase to urban and rural prices, however, essentially freezes into place the 1982 cost differential. Consequently, Congress should examine the extent to which product changes have occurred that necessitate corrective action and consider the establishment of a separate update factor for rural hospitals.

Outlier Policy

The inadequacy of outlier policy is possibly the most important issue posed by the current system, because it is one of the features of the system that could be readily adjusted. In urban areas, and for larger rural hospitals, outlier policy is problematic primarily due to the disproportionate number of outlier patients treated by certain hospitals. In rural areas, and for smaller hospitals, outlier policy is troublesome because of the substantial losses that can be experienced on even a few outlier cases. In both instances, the underlying cause of difficulty is the inadequate rate of compensation provided for outlier patients and the relatively restrictive definition of an outlier case.

As an example: For an average DRG, i.e., a DRG with a cost weight of 1.0, the outlier threshold for cost outliers is $13,000. A patient who incurs costs of $15,000 meets this threshold, but the supplemental payment is only $1,200, i.e., 60 percent of the difference between the threshold and the patient's estimated cost. The total payment for such a patient is the price, for the average rural hospital approximately $2,350, plus the $1,200 supplemental payment, or $3,550. The loss that must be made up by the hospital is $11,450. Given a sufficient volume, such a loss can be made up, but in small hospitals it is often not possible to do so.

One further problem that should not be neglected is the decision by HHS to use length of stay as the primary criterion for determining the outlier status of patients. Patients who not only qualify as cost outliers but also have extended hospital stays must be paid according to the per-diem length-of-stay outlier method. Often these payments are considerably less than those for cost outliers, compounding the problems created by the current cost-outlier payment method.

The problems experienced by rural hospitals are often caused by the same factors that lead to problems in urban hospitals, such as inadequate outlier payments. But in rural hospitals the problems appear more acute because the margin of safety is smaller in smaller hospitals. The law of large numbers that underlies the DRG-pricing concept simply does not hold for many of these hospitals, given the magnitude of problems with the DRG system.

Access to Post-Acute Services

A final issue involves the rural hospital's role in assuring access for its acute-care patients to post-acute health services. In view of the incentives in the prospective pricing system for efficiency in the delivery of acute health services and the criteria for PROs in reviewing appropriateness of care, there is increased emphasis on coordinating inpatient and outpatient, acute and non-acute, short-term and long-term, and hospital-based and alternative care.

One effect of the prospective system has been highlighting of the existence of many different levels of medical need both within and without the categories of "hospital," "skilled nursing," and "home health" care. This leads to the need for reassessment of the Medicare benefit, establishment of medical review criteria that differentiate between levels of care, identification of providers capable of delivering each level of care, and assurance of continuity of care across levels.

Examples of flexible approaches to providing access include swing-bed utilization and treatment of "administratively necessary days." The AHA supported demonstrations of the swing-bed concept--alternating beds between acute- and long-term care, depending upon patient and community need--in four states, including Texas, with Hi-Plains Hospital one of the demonstration sites. When swing-bed utilization was made part of the Omnibus Reconciliation Act of 1980, the AHA opposed restricting usage to rural hospitals with fewer than 50 beds. The Association supports H.R.3000, introduced by Representative Dorgan, which would extend swing-bed participation to rural hospitals having as many as 150 beds, and urges this Subcommittee to consider similar legislation.

The AHA also supports recognition of administratively necessary days. A provision on such days is included in S.2331, the Medicare Quality Assurance Act of 1986. It would require HHS to study the treatment of days spent in the hospital awaiting placement in a skilled nursing facility (SNF). It would determine the extent to which current prices include and adequately reflect the actual costs of providing these services and whether additional payments should be made for them.

Current HHS policy prohibits hospitals from issuing notices of noncoverage to inpatients who are not at acute levels of care but are awaiting placement in SNFs. As a result of the increasing scarcity of available Medicare-covered SNF services, hospitals are more often keeping patients who do not need acute care, without any additional Medicare payment.

HHS should consider ways of enhancing the ability of hospitals to furnish post-acute services while ensuring payment for any additional services hospitals provide.

PAYMENT ADJUSTMENTS FOR SOLE COMMUNITY PROVIDER HOSPITALS

The Social Security Amendments of 1983 mandated that hospitals that are sole providers of care in their communities permanently receive a payment rate per Medicare discharge that is composed of a 75-percent hospital-specific component and a 25-percent federal component. The hospital-specific component is computed only once. It is based on a hospital's operating costs in its prospective pricing base year, i.e., FY 1983.

The amendments also established a prior special adjustment category for sole community hospitals with declining discharges: for cost reporting perioids beginning on or after October 1, 1983, but before October 1, 1986, facilties experiencing more than a 5-percent decline in inpatient discharges can receive a payment adjustment.

Both COBRA and regulations proposed by HHS in the March 10, 1986 Federal Register offer a second category of special treatment for such providers: an adjustment due to additional operating costs incurred as a result of addition or expansion of a hospital to meet community medical needs.

The AHA supports the establishment of the special adjustment option to account for added capacity, and has asked HHS to broaden the application procedure it proposes for it and to make its implementation permanent. In addition, due to the importance of the hospital-specific component in the sole community hospital payment methodology, the Association urges adoption of a mechanism to reflect changes that occur in a hospital's average cost per case for reasons related to patient care.

Because most sole community providers are small, rural hospitals with fluctuating case mixes and volumes, a per-case payment system is inappropriate as a foundation for the payment methodology. Although the AHA supports the special adjustment in the short term, it views special treatments as administratively burdensome overall, and advocates a return to cost-based reimbursement for sole community providers. Cost-based reimbursement would recognize changes in costs related to case mix, admission declines, and modifications in community demand. Given that only 326 hospitals nationwide presently have sole community status, a return to cost-based reimbursement would represent little adverse impact for the Medicare program. The AHA urges that this Subcommittee consider a legislative provision to revise the payment method.

CONCLUSION

Mr. Chairman, as I stated earlier, the AHA has a Special Committee on Small or Rural Hospital Care that has identified numerous issues facing small or rural hospitals, some of which I have mentioned today. The committee is examining these issues and plans to have preliminary recommendations this fall and a final report early in 1987. In advance of the panel's work, I have singled out certain problems that relate primarily to the Medicare program: rural referral centers, the area wage index, volume fluctuations, discrepancy between urban and rural rates, uniform updating factor, outlier policy, access to post-acute services, and payment adjustments for sole community provider hospitals.

There are additional concerns, ones that relate primarily to administrative burdens on small, rural hospitals. Paperwork can be a problem for small facilities, as can adaption of data processing systems for electronic medical claims submission to fiscal intermediaries.

When rural hospital administrators get together, as on the governing council of the Section for Small or Rural Hospitals, we talk about the increasing difficulty of preserving quality of care in our hospitals, in a time of budget cuts, reduced state resources, and declining admissions. We share information about the effects of depressed economies in rural areas, in the nation's breadbasket and its oil patch; about increasing numbers of uninsured and underinsured individuals that need care, resulting in greater uncompensated care and bad debts; about the high proportion of elderly that live in rural communities, resulting in a greater proportion of Medicare inpatient revenue; about aging plant and equipment and difficulties in acquiring capital funds; and about the effects of some small or remote rural hospital closures on access to health care services.

This hearing is an opportunity for dialogue on numerous issues facing rural hospitals today. The American Hospital Association pledges to work with you in seeking solutions to problems that inhibit rural hospitals in providing needed services to their communities.

PREPARED STATEMENT OF JUDITH CLEVEY, PRESIDENT, HOSPITAL COUNCIL OF EAST CENTRAL MICHIGAN

I AM JUDITH CLEVEY, PRESIDENT OF THE HOSPITAL COUNCIL OF EAST CENTRAL MICHIGAN, A DISTRICT HOSPITAL COUNCIL WHICH REPRESENTS 23 HOSPITALS IN THE 14 COUNTY AREA WHICH INCLUDES SAGINAW, NORTH TO TAWAS AND HOUGHTON LAKE, WEST TO MIDLAND AND THE THUMB. I AM MOST PLEASED TO BE HERE TODAY TO DISCUSS THE HEALTH CARE NEEDS OF THE ELDERLY.

FIRST, LET ME DESCRIBE SOME OF THE CHARACTERISTICS OF THE ELDERLY POPULATION IN OUR AREA. IN 1985, 13% OF THE POPULATION IN EAST CENTRAL MICHIGAN WAS OVER 65 YEARS OF AGE COMPARED TO THE REST OF THE STATE WHICH HAS 9.85% OF ITS CITIZENS AS OVER 65 YEARS OF AGE. THE POPULATION GROUP OF OVER 65 YEARS OF AGE IS GROWING RAPIDLY AND WILL INCREASE BY 18%. BUT MOST STARTLINGLY, THE POPULATION GROUP OF OVER 85 YEARS WILL GROW BY 50%. INDEED, THE PERCENTAGE OF GROSS PATIENT REVENUE PPOVIDED BY MEDICARE TO OUR HOSPITALS HAS INCREASED BY 8% SINCE 1980.

HOW DOES THIS GROWTH RATE IMPACT HOSPITALS? WE KNOW THAT THOSE OVER 65 YEARS OF AGE USE HOSPITALS FIVE TIMES THE RATE OF THE 15-44 AGE GROUP. IT IS ALSO THE LARGEST CONSUMER OF DRUGS AND HOME HEALTH CARE SERVICES. YET COMPARED TO OTHER PARTS OF THE STATE, HOSPITAL UTILIZATION AND COST IS LOW IN EAST CENTRAL MICHIGAN. THE AVERAGE LENGTH OF STAY FOR THE ELDERLY IS THE SECOND LOWEST IN THE STATE, WHILE THE COST OF CARE IS THE THIRD LOWEST IN THE STATE. WHAT DO HOSPITALS SEE AS PROBLEMS FACING THE ELDERLY AND THE RURAL ELDERLY.

FIRST, THE CHANGES IN THE PAYMENT SYSTEM FOR MEDICARE WITHOUT PAYMENT FOR TRANSITIONAL CARE IS PLACING A BURDEN ON THE ELDERLY. WHILE THE EMPHASIS BY MEDICARE IS TO LIMIT THE TIME IN THE INPATIENT SETTING, THERE IS NO RECOGNITION OF THE LACK OF SERVICES TO THE ELDERLY FOR CONTINUITY OF CARE IN THE RURAL AREAS. WHERE SERVICES ARE AVAILABLE, OFTEN REIMBURSEMENT IS NOT. OUR HOSPITALS ARE NOW FACED WITH THE PROBLEM OF RELEASING PATIENTS WHO MAY NOT BE SICK ENOUGH FOR A HOSPITAL BED BUT DO NOT HAVE ADEQUATE SUPPORT BY FAMILY OR LOCAL AGENCIES FOR CARE. PAYMENT FOR TRANSITIONAL CARE, PERHAPS IN A HOSPITAL BED BUT AT A LESSER RATE WOULD ALLEVIATE MANY OF THE PROBLEMS PATIENTS FACE.

HOWEVER, AT A TIME WHEN THE NEEDS OF THE ELDERLY ARE GREAT, THE CONGRESS IS CUTTING THE MEDICARE BUDGET. MEDICARE REDUCTIONS FROM 1981 THROUGH 1985 HAVE TOTALLED NEARLY $40 BILLION. THAT'S 12% OF THE TOTAL FEDERAL CUTS TO THE BUDGET EVEN THOUGH MEDICARE REPRESENTS ONLY SEVEN PERCENT OF THE TOTAL FEDERAL OUTLAYS. IN CONTRAST, DEFENSE SPENDING HAS BEEN ON THE RISE. SINCE 1981, IT HAS GROWN FROM 22% OF TOTAL FEDERAL

OUTLAYS TO 26.3%. DURING THE SAME PERIOD, MEDICARE SPENDING AS A PERCENTAGE OF FEDERAL OUTLAYS HAS DECLINED FROM 7.6% TO 7.1%. FURTHER, THE REAGAN ADMINISTRATION WANTS TO REDUCE MEDICARE SPENDING BY AN ADDITIONAL $50 BILLION BY 1991.

MEDICARE BENEFICIARIES NOW SPEND ABOUT 15% OF THEIR INCOME ON HEALTH CARE IRONICALLY, THE SAME PORTION THEY SPENT PRIOR TO THE ESTABLISHMENT OF THE MEDICARE PROGRAM. EVEN IN THE ABSENCE OF ADDITIONAL INCREASES IN COST SHARING AND PREMIUM AMOUNTS, ELDERLY OUT OF POCKET EXPENDITURES FOR MEDICAL CARE WILL INCREASE TO ABOUT 20% OF TOTAL INCOME BY THE YEAR 2000.

IN 1984, OLDER AMERICANS SPEND $10 BILLION JUST TO MEET MEDICARE DEDUCTIBLE AND COINSURANCE REQUIREMENTS A 200% INCREASE OVER 1977. LAST YEAR, THE HOSPITAL DEDUCTIBLE ALONE ROSE BY 23% FROM $400 TO $492 AND IT WILL GO UP AGAIN IN 1987.

ACCESS TO PHYSICIANS IS ALSO A PROBLEM FOR THE RURAL ELDERLY AND THIS PROBLEM IS BEING EXACERBATED BY THE UNWILLINGNESS OF PHYSICIANS TO PRACTICE IN MICHIGAN DUE TO THE MEDICAL MALPRACTICE LIABILITY CRISIS. THE MAJORITY OF THE EAST CENTRAL MICHIGAN AREA IS ALREADY MEDICALLY UNDERSERVED AS DEFINED BY FEDERAL AND STATE STANDARDS. THE LIABILITY CRISIS IS CONTRIBUTING TO THE ALREADY SEVERE ACCESS PROBLEM.

WHAT CAN CONGRESS DUE TO HELP ALLEVIATE THESE PROBLEMS:

1) PROVIDE FAIR AND EQUITABLE PAYMENTS TO HOSPITALS FOR MEDICARE BENEFICIARIES, INCLUDING APPROPRIATE AREA WAGE INDICES, DISPROPORTIONATE SHARE ADJUSTORS AND INCREASES IN PAYMENTS TO ACCOUNT FOR INFLATION.

2) PROVIDE ADEQUATE CAPITAL REIMBURSEMENT TO THE PROSPECTIVE PAYMENT SYSTEM BY ALLOWING FOR A LONGER TRANSITION PERIOD TO NATIONAL PRICES, THE MOST RECENT FULLY AUDITED COST DATA AND RECOGNIZING THE FULL COST OF CAPITAL.

3) PROVIDE TRANSITIONAL PAYMENT RATES FOR LESS ACUTE SETTINGS FOR THOSE ELDERLY PATIENTS WHO ARE NOT ILL ENOUGH FOR A HOSPITAL SETTING BUT NEED ADDITIONAL CARE.

4) RECOGNIZE THAT A BALANCED FEDERAL BUDGET SHOULD BE BALANCED IN ITS APPROACH TO CUTTING PROGRAMS - NOT ALL OF THE CUTS SHOULD COME FROM PUBLIC HEALTH PROGRAMS.

5) ENACT FEDERAL LEGISLATION TO CAP NONECONOMIC DAMAGES AND PROVIDE NECESSARY TORT REFORM TO CONTAIN THE CURRENT LIABILITY CRISIS.

6) CONTINUE SUPPORT FOR OTHER HEALTH PROGRAMS FOR THE ELDERLY SUCH AS HOME HEALTH CARE, MEALS ON WHEELS AND SCREENING PROGRAMS.

7) REVIEW THE ACTIVITIES OF HCFA IN RELATION TO THE PRO ACTIVITIES. OUR HOSPITALS ARE CONTINUALLY FACING PROBLEMS WITH "MONDAY MORNING QUARTERBACKS" REVIEWING PATIENT CHARTS AND EITHER DENYING PAYMENTS OR DAYS BECAUSE THEY FEEL THAT A PATIENT IS NOT SICK ENOUGH TO WARRANT CARE. ALSO, HCFA MUST BE INSTRUCTED TO RELEASE HOSPITAL SPECIFIC DATA IN A CLOSELY MONITORED AND ACCURATE FASHION. THE RECENT HCFA MORTALITY RATE STUDY WAS NOT HELPFUL TO THE CONSUMER OR THE HOSPITAL INDUSTRY.

THANK YOU FOR ALLOWING ME TO ADDRESS SOME OF OUR CONCERNS. WE WISH TO CONTINUE TO PROVIDE QUALITY CARE TO THE ELDERLY, ESPECIALLY THE RURAL ELDERLY, BUT NEED THE ASSISTANCE OF CONGRESS IN PROVIDING SUCH CARE.

PREPARED STATEMENT OF DR. JAMES FRYFOGLE, THORACIC-CARDIOVASCULAR SURGEON, ROSCOMMON, MI.

I AM DR. JAMES FRYFOGLE, A THORACIC-CARDIOVASCULAR SURGEON NOW LIVING IN ROSCOMMON COUNTY. I SERVE ON THE STATE HEALTH COORDINATING COMMITTEE OF MICHIGAN.

I SPEAK FOR THE W. D. FRYFOGLE MEDICAL RESEARCH LABORATORY, A NON-PROFIT ORGANIZATION THAT FOR THE LAST 25 YRS. HAS TRAINED MEDICAL PERSONNEL IN RESEARCH PROTOCOL, DIVISED AND PERFECTED INSTRUMENTS AND TECHNIQUES NEEDED IN THE FIELD OF THORACIC AND CARDIOVASCULAR SURGERY -- AND SERVED AS CONSULTANT AND PATIENT ADVOCATE OF AMBULATORY MEDICAL AND SURGERY FACILITIES AT FEDERAL, STATE, AND LOCAL LEVELS.

OUR INTEREST IN THE "HEALTH" OF NORTHERN LOWER MICHIGAN IS LONG STANDING....WE HAVE WATCHED WITH PLEASURE AS TRAVERSE CITY AND PETOSKEY DEVELOPED AS MODERN MEDICAL CENTERS. OUR AREA OF CONCERN IS EXPRESSED ON THE ENCLOSED MAP. THE THREE HOSPITALS INCLUDED HAVE NOT SHARED IN THIS TECHNICAL ADVANCE, AND THEIR INFLUENCE AFFECTS APPROXIMATELY 100,000 CITIZENS.

YOU WILL NOTE THAT THE CIRCLES OF THEIR PATIENT CARE AREA INTERSECT AT HOUGHTON LAKE....RIGHT WHERE WE ARE STANDING...SO WE ARE ON THE FRINGE OF WHAT CARE THESE HOSPITALS CAN GIVE US.

ALSO, IF YOU LOOK AT THE POPULATION FIGURES OF THE COUNTIES INVOLVED, YOU WILL SEE THE RAPID RISE IN ROSCOMMON COUNTY, ALMOST A THIRD MORE SINCE THE PREVIOUS CENSUS....MANY OF THESE NEWCOMERS ARE RETIRED CITIZENS WHOSE NEED OF HEALTH CARE AND FACILITIES IS REAL. ALSO, THE GREATEST NUMBER OF THESE NEWCOMERS ARE IN THE SOUTHERN PORTION OF ROSCOMMON COUNTY NEAR HOUGHTON LAKE.

THEY NEED AN INCREASE IN HEALTH PERSONNEL AND PROGRAMS. I ENCLOSE FOR YOU A COPY OF THE RAND - McNALLY RETIREMENT GUIDE 1985. IT LISTS THE 107 BEST PLACES IN AMERICA FOR RETIREMENT LIVING.

THE 107 CAREFULLY SELECTED PLACES ARE RANKED AND COMPARED FOR CLIMATE, HOUSING FACILITIES, HEALTH CARE, PERSONAL SAFETY, ECONOMICS AND RECREATION.

ROSCOMMON COUNTY IS RANKED 107th LARGELY BECAUSE IT CANNOT PROVIDE ADEQUATE HEALTH CARE!

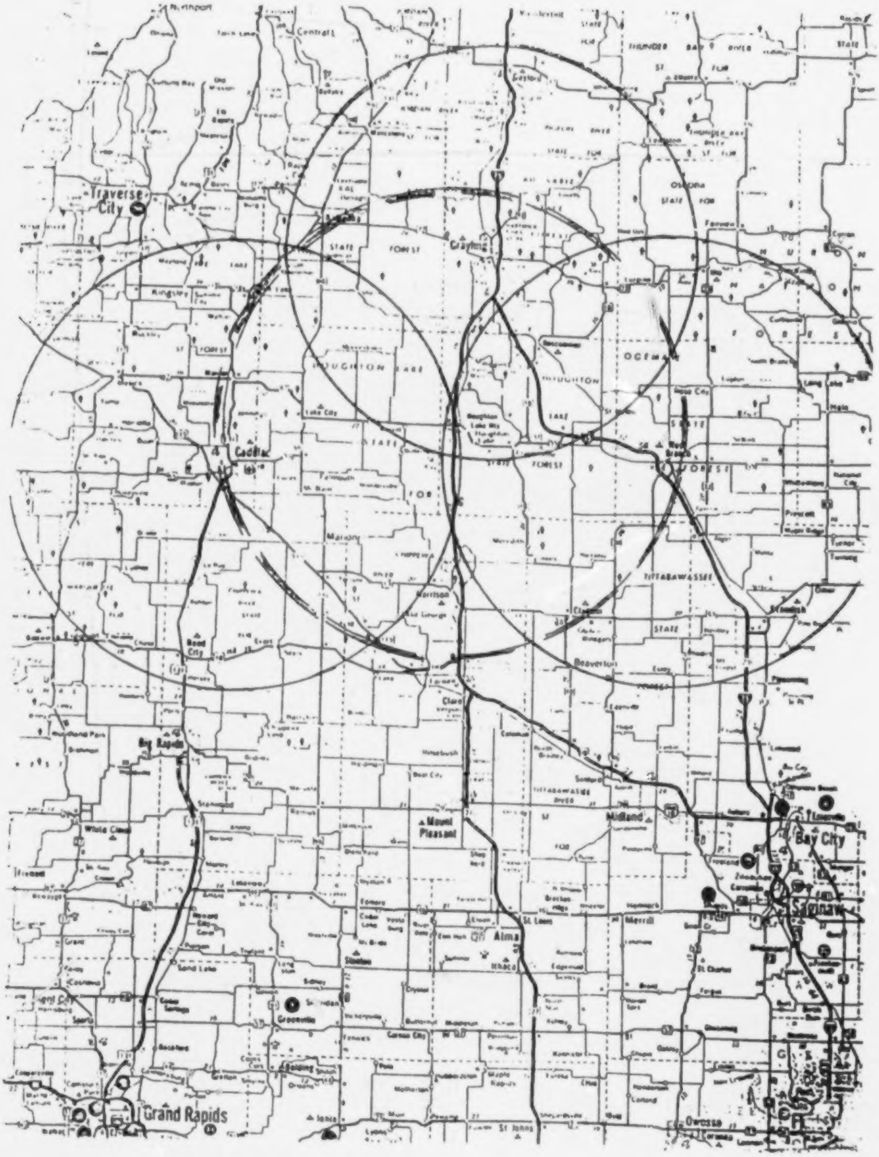
ALSO ATTACHED IS A SAMPLE COMPARISON BETWEEN MIAMI, FLORIDA RANKED #1 IN HEALTH CARE, AND HOUGHTON LAKE, MICHIGAN - #107.

WITH THE HELP OF KIRTLAND COMMUNITY COLLEGE AND THE COOPERATION OF THE THREE HOSPITALS WE HOPE TO CHANGE ROSCOMMON'S RANKING AND PROVIDE ADEQUATE DIAGNOSTIC, TREATMENT, AND SUPPORT PROGRAMS FOR ITS CITIZENS.

NOTES FOR CONGRESSMAN SCHUETTE

1) WE HAVE TWO BASIC "LACKS" IN THE AREA -
    A) Technical expertise
    B) Medical personnel
2) MOST OF THE DOCTORS IN THE AREA (78%) ARE UNDER 45 YRS. OF AGE --
    THIS MEANS THAT MOST WERE EXPOSED DURING THEIR TRAINING YEARS TO CATSCANS, ANGIOGRAMS, ULTRASOUND, CHEMOTHERAPY, CHEMICAL AND PHYSIOLOGIC TESTING (CARDIAC-PULMONARY) PACEMAKER THERAPY
3) NONE OF THESE, OR ONLY ABBREVIATED VERSIONS OF THEM, ARE AVAILABLE TO THE MEDICAL COMMUNITY AND THEN THE LEVEL OF PRACTICE SUFFERS.
4) I AM HOPEFUL THAT CAT-SCANNERS WILL BECOME AVAILABLE (after a 10-year delay). THE BILL ON RULES AND REGS IS ON THE S.H.C.C. AGENDA FOR MAY.
5) WHILE WE NEED DOCTORS (primary care)WE LACK ESSENTIAL SPECIALISTS.....WE HAVE NO CERTIFIED CARDIOLOGIST IN THE ENTIRE AREA.
    IT IS ALMOST IMPOSSIBLE TO RECRUIT PHYSICIANS OR SPECIALISTS TO THE AREA UNLESS THEY CAN BE PROVIDED THE TECHNICAL FACILITIES NEEDED TO PRACTICE THEIR PROFESSION.

    ...DESPITE THE FACT THAT THIS IS THE MOST BEAUTIFUL PART OF AMERICA, WE HAVE PROBLEMS!


Northport
Traverse City
Gaylord
Grayling
Kingsley
Houghton Lake
Oscoda
Cadillac
West Branch
Reed City
Harrison
Beaverton
Standish
Clare
Big Rapids
Mount Pleasant
Midland
Bay City
White Cloud
Saginaw
St Louis
Alma
Ithaca
Greenville
Grand Rapids
St Johns
Owosso

8. *Fluoridation.* A retirement place receives 200 points if it has fluoridated drinking water, either natural or adjusted.

Sample Comparison: Miami, Florida, and Houghton Lake, Michigan

As we have already seen, the larger metro areas tend to have more health-care facilities and options for retirees than do the small non-metropolitan counties. The place that ranks first among the retirement places for health-care facilities is Miami, a large city long famous as a retirement destination. While Miami certainly has its problems in other areas (most notably crime), there's no denying that in health-care choices and services it offers the most. The place receiving the fewest points for health care is Houghton Lake, Michigan, a resort area near the center of the state.

First let's see how Miami achieved its number-one ranking. To begin with, Miami has 295 physicians for every 100,000 residents; this is well over the national average and is worth 295 points. For its 682 hospital beds per 100,000 residents (in 39 hospitals), Miami receives ½ point apiece, or 341 points. Miami's medical school—the University of Miami School of Medicine—and three teaching hospitals are worth 200 points apiece, for a combined score of 800 points. The metro area also earns 100 points each for its comprehensive cancer treatment center, six community mental health centers, hospice, and all four of the health-care options—cardiac intensive care, outpatient hemodialysis, outpatient psychiatric services, and home nursing care—for an additional 1,200 points. And finally, Miami's drinking water is fluoridated, worth 200 points. The total score for Miami is 2,836, which places it comfortably in the leading slot, almost 700 points ahead of runner-up Tucson.

At the other end of the scale is Houghton Lake, Michigan, ranking 107th. Its ratio of physicians is 62 per 100,000 residents, way below the national average and worth 62 points. And this marks the extent of the medical services for which Houghton Lake can receive points. Houghton Lake has no hospitals and therefore no hospital beds. It has none of the other health-care facilities that receive points in the *Places Rated* scoring system, not even fluoridated drinking water.

This does not mean that Houghton Lake is not a good place to live; it does mean that for most health-care services, residents must go elsewhere. For example, the retirement place that ranks 15th—Traverse City-Grand Traverse Bay, Michigan—is about 65 miles away. People who opt for Houghton Lake may decide that the inconvenience of an occasional trip to a larger city is outweighed by the beauty and serenity of Roscommon County.

Health-Care Winners and Losers

When the final ranking list for health care is examined, a definite pattern emerges reflecting place size and availability of health-care services and facilities. Of the top 20 ranked places, for example, only four are non-metro areas. One of these, San Luis Obispo, California, is large enough so that it soon will become one. Two of them—Traverse City-Grand Traverse Bay, and Petoskey-Straits of Mackinac, both in Michigan—are near enough to each other to form a nexus of smaller towns that might also include Charlevoix and Harbor Springs. All of these places have long been noted for the high incomes and educational level of their residents.

At the bottom end of the list (the 20 lowest-scoring places), only one retirement place—Olympia, Washington—is a metro area, illustrating the direct relationship between city size and the abundance of facilities (be they health-care, cultural, educational, recreational, or other) to be found there.

Health-Care Facilities

Best Retirement Places	Places Rated Score	Worst Retirement Places	Places Rated Score
1. Miami, FL	2,836	1. Houghton Lake, MI	62
2. Tucson, AZ	2,142	2. Ocean City-Assateague Island, MD	64
3. Albuquerque, NM	2,110	3. Rappahannock, VA	87
4. Lexington-Fayette, KY	2,102	4. Table Rock Lake, MO	93
5. San Diego, CA	2,067	5. Canton-Lake Tawakoni, TX	125

Why then should anyone prefer the smaller places? First of all, many smaller places are close to big ones, and their residents can enjoy the benefits of small-town life and—with a reasonable commute—the amenities of a big city. Virginia's Rappahannock River area is within 50 miles of the metro area of Richmond; Rockport-Aransas Pass, on Texas's Gulf Coast, is within 20 miles of Corpus Christi; residents of Clarkesville-Mount Airy, Georgia, lying midway between Asheville, North Carolina, and Atlanta, have the choice of a large metro area or a small one within reasonable driving time.

Remember, too, the disadvantages of big metro areas. Although they almost always do better on facilities, they often fall down on social indicators such as the crime rate. If you look at the crime rates in the various retirement places, you will see a ranking list that is almost the reverse of that in health care: The larger places almost always have more crime.

PREPARED STATEMENT OF KATHERINE GROSSER, DIRECTOR, HEALTH OPERATIONS, KIRTLAND COLLEGE, ROSCOMMON, MI

I am Katherine Grosser, Director of Health Occupations at Kirtland College, in Roscommon, Michigan, and on behalf of the college community I would like to take this opportunity to voice our concern regarding the availability and quality of health care for the elderly in rural Michigan.

Kirtland is committed to meeting the needs of its citizens and has impacted the availability and quality of health care in this area through the development and implementation of educational programs for the providers of that care. Kirtland's emphasis lies in three major areas;

1. Preparation for entry level employment,
2. Preparation for transfer to 4 year colleges and universities, and
3. Continuing education.

Kirtland's Practical Nursing program has been in existence for 14 years, and the Associate Degree Nursing program is just beginning its fourth class. The impact of these 2 programs to our community hospitals is substantial.

52% of the licensed practical nurses who provide care at our 2 community hospitals are graduates of Kirtland Community College and after just two graduating classes, the Associate Degree nurse graduates of Kirtland comprise 31% of all Associate Degreed Registered nurses in these same community hospitals.

As a member of the Saginaw Valley State College Advisory Board and a member of the Ferris State College Consortium, Kirtland has fostered an environment wherein graduates of our nursing program may move into Baccalaureate programs with minimal course repetition and validation. This emphasis on articulation to the 4 year colleges will ultimately increase the availability of Baccalaureate prepared nurses and provide the nursing leadership for the future.

In addition to Kirtland's commitment to nursing education, customized training for personnel at local health-extended care facilities has also been provided via the quick-start program. A repeat of this program will soon be implemented for Hilltop Manor in Roscommon as they begin to address their staffing needs. Kirtland also provides ongoing training for Adult Foster Care Providers within the 4 county area.

And, finally, Kirtland plans to broaden the current continuing education offerings on campus to include health professionals and a grant application has just been developed for this purpose. It is our intent to offer specific programs to home health care providers, and through seminars and workshops to broaden the knowledge base of all allied health personnel in the area of gerontology.

Thank you.

PREPARED STATEMENT OF THE MICHIGAN HOSPITAL ASSOCIATION, LANSING, MI

The fastest growing segment of the U.S. population is over age 65. According to the U.S. House Select Committee on Aging, the number of senior citizens in the country will double over the next 45 years. In Michigan, the percentage of the population over age 65 is already approaching 11 percent.

A recent report issued by the Michigan Office of Services to the Aging indicates that 28.3 percent of the older population is over the age of 75 living in either small towns (30.8 percent) or rural areas (18.0 percent). (Michigan Needs Assessment of the 60 and Over Population, April 1986). According to that report, the most serious perceived problem among the older population is poor health.

Although older adults account for only 11 percent of Michigan's population, they account for about one third of all health care expenditures. Older people have a higher incidence of most chronic conditions and of certain types of accidental injuries. Additionally, these chronic conditions and injuries dramatically affect their degree of personal independence and the overall quality of life.

According to the U.S. Department of Health and Human Services, Health Care Financing Administration, the five most common DRGs for prospective payment discharges reported fiscal year 1984 to date were: Heart failure and shock, digestive disorders, lens procedures, pneumonia and pleurisy and cerebrovascular disorders.

The American Hospital Association contends that chronic conditions -- arthritis, hypertension, hearing impairments, cancer and heart conditions affect 86 percent of seniors. These figures, juxtaposed with population projections that seniors will comprise 11 percent of our state's population by 1990, suggest that serious attention be given to the issue of adequate health care for Michigan's elderly. As our society moves away from the female family member as primary caretaker -- due to infirmity, employment or unavailability of that family member, our social support systems, including hospitals, will take on new roles as service providers.

This new role of service provider may be especially difficult for Michigan's rural health care providers. It can be argued that there is a direct relationship between health status and access to health services. We know that there is great concern over physician availability in rural areas. In 1984 there were 21,149 physicians in the State of Michigan, yet only 1010 of those physicians served the northern section of the state and the entire upper peninsula. Likewise, rural areas may be deficient in other medical professional personnel, as well as in health care facilities themselves.

Many rural hospitals have been negatively affected by recent changes in Medicare legislation -- many contend that small and rural hospitals should be exempt from the Prospective Payment System. Similarly, appropriateness for hospitalization under the prospective payment system should include consideration of each patient's social and environmental factors preceding hospital admission.

The National Rural Health Care Association calls the rural hospital the key provider of services to the elderly population in the rural area. Small community hospitals have taken the lead in establishing special clinics, home care, day care and skilled nursing services. One such initiative may soon be available to Michigan hospitals. Michigan House Bill 5143 would allow hospitals to convert underutilized beds for past-acute hospital care. Those who cannot obtain the support services at home could utilize the subacute services that would be available in the hospital setting. Hospital discharge planning would work, as they do now, at finding appropriate community resources for the convalescence. Patients would not necessarily be admitted into these special rehabilitative units, but would be transferred to them only when costly acute care was no longer needed.

With the advent of DRGs and the subsequent lowered length of hospital stays, it has become necessary to reevaluate our perception of hospital care. Senator William Proxmire recently stated that patients must be educated that there is a difference between needing acute hospital services and feeling fine. As patients are discharged when acute care is no longer necessary, but not yet "feeling fine," we must educate ourselves and our patients that the care once provided within the hospital must be sought in a different setting at a much lower cost.

The Michigan Hospital Association supports home health initiatives and ventures that allow hospitals and their professionals to develop quality home health programs which can provide older adults with the assistance they need while maintaining autonomy and self respect. In rural areas especially, mobile health services may be required to meet the needs of older adults as transportation becomes increasingly difficult. Programs like these encourage the older adult to stay in familiar surroundings while obtaining quality care for their varied nutritional, rehabilitative and psychological needs.

MHA suggests that the health services available to older adults should range for illness prevention and health promotion programs to the fulfillment of their chronic health care needs. We welcome the challenge to provide quality care for Michigan's older adults.

PREPARED STATEMENT OF DOROTHY PINNER, R.N., M.S.N., EXECUTIVE DIRECTOR, VISITING NURSES ASSOCIATION OF MID-MICHIGAN

Visiting Nurse Association of Mid-Michigan is a Medicare-certified agency and provides services to beneficiaries in their homes who are in need of a skilled level of care on an intermittent basis. Our service area covers Midland, Clare, Gladwin Counties and portions of Bay, Saginaw and Isabella Counties. More than 50% of our total visits are in the rural areas outside of the city of Midland.

Our agency has worked in concert with many of the following agencies in order to provide health care to the elderly in our service area. Our agency has not refused to care for a client who has been referred to us and I am confident that the other providers have not refused either. Therefore, when I read statements about the elderly going home without the needed health care, the problem is not the lack of home health agencies but is usually due to the lack of referral from physicians,hospitals or other agency personnel who are not aware of the available services. This was evidenced by the testimony presented by Jeff York from the Midland County Council on Aging. Many of the examples he presented could have been referred to home care agencies and perhaps the patients' complications would have been prevented. The following agencies provide home health services in our service area and are available on a 24-hour basis:

Medicare-Certified Agencies:

Visiting Nurse Association of Mid-Michigan	(above counties)
Visiting Nurse Association of Saginaw	(Saginaw County)
Central Michigan Health Department	(above counties)
Michigan Home Health Care, Inc.	(Isabella-Clare
Mid-Michigan Home Health Agency,Inc.	(above counties)
Allen Home Care	(Mid.Bay,Saginaw)
Upjohn Healthcare Services	(Mid,Bay,Saginaw)
Bay Medical Home Care	(Midland,Bay)
Bay County Health Department	(Bay County)

Private-Duty 24 hour Home Care

Home Health Services of Mid-Michigan	(above counties)
Upjohn Healthcare Services	(above counties)
Quality Care	(above counties)
Temporary Health Care Providers,Inc.	(above counties)
Allen Health Care	(above counties)
People Care	(above counties)

All of the above agencies provide professional nursing services besides a combination of other professional and paraprofessional services. All of the above agencies bill third party payors and/or the client for services.The majority of the agencies also provide services to those unable to purchase services either through the use of United Way funds, memorials, donations, endowments or direct agency funds.

Additional Home Care Services (paid through grant monies)
(client makes donation if able)

Gladwin City Housing -personal care,homemaking,companion,chore services,case management (Clare-Gladwin)

Midland County Council on Aging-homemaking,companion,chore serservices,case management (Midland)

Bay County Council on Aging- homemaking,companion, chore serservices,case management (Bay)

Visiting Nurse Association of Saginaw-personal care,homemaker

Saginaw County Council on Aging- chore, case management

Congressman Schuette, as you can see from the above list of providers , there is a rather complete service network available to our beneficiaries; however, many factors hinder our elderly citizens from benefiting from the services already available.

1. Medicare guidelines have become so restrictive for beneficiaries to even qualify for the home health services. Agency personnel have to discuss these restrictions with the client and request some form of payment, co-payment or determine eligibility to subsidized care and the client often refuses services at this point due to financial restraints.

2. Agencies are less able to provide services to the indigent due to decreased reimbursement, increased denials with loss of revenue, cash flow problems due to slower processing of claims by fiscal intermediaries and smaller margins for any net incomes.

3. Decreased personal income of clients to purchase services not covered by insurances.

4. Lack of coordinated discharge planning by some hospital personnel who are unaware of existing health services.

5. Lack of physician awareness of existing home health services

6. Lack of knowlege of home health care needs and availability of health care services by case managers in local aging networks.

In summary, I do not believe that the creation of additional ,or new services ,which again will require funding and create new administrative costs, would be the most prudent method to use to solve the problem of lack of services for the rural elderly.
One approach would be to examine what services are already available through existing agencies and develop better methods of informing the public,physicians, discharge coordinators and case managers working with the elderly through the aging networks.

Another approach would be to examine the feasibility of providing the necessary funding, either through grants, reimbursement, etc.,to the existing agencies delivering health care rather than starting up special grant projects to deliver small segments of health care who do not employ health personnel to provide a holistic approach to the clients health needs.

Congressman Schuette, I would end with a question. What advantage would it be to continue funneling more money into the area of case management if the agencies providing the skilled or basic level of care continue to have greater restrictions placed upon them by our government and would eventually have to either stop accepting the Medicare recipient or go out of business,where would the case manager then refer recipients for home health care?

R

THE MEMORIAL HOSPITAL

826 WEST KING STREET • OWOSSO, MICHIGAN 48867

May 28, 1986

Ms. Alison Carberry
c/o Congressman Bill Schuette
415 Cannon Bldg.
Washington, D.C. 20515

Dear Ms. Carberry;

My name is: Ron Rybar

My position is: Vice President of Finance
The Memorial Hospital
Owosso, Michigan 48867

I would like to submit this as written testimony to your Aging Committee Hearing at Houghton Lake regarding Rural Health Care.

The enactment and implementation of the Prospective Payment System in 1983 had led to a radical change in the health delivery system for hospitals and other healthcare providers. Efficiencies in the hospital system have permitted the federal government to virtually freeze DRG payment levels over the past three years.

The system is set up to make two different payment levels depending upon whether the county in which the hospital is located is designated as urban or rural for Census Bureau purposes. The intention of the Census Bureau in making these county designations was never to provide a basis for determining payment levels to hospitals. This inconsistency causes hospitals less than 30 miles away from The Memorial Hospital to be paid over $1200 more for treating patients with the same disease. This inequity exists even though The Memorial Hospital has similar labor, supply, fuel, and building costs as our neighbors.

Congressman Schuette has followed very closely our struggle to be paid at an appropriate level for rendering services to Medicare patients. He has seen the need to insure access for the elderly in Shiawassee County to high quality health care services. He and his staff have worked closely with the office of Management and Budget and the Health Care Financing Administration to find a solution to this difficult problem. We hope to resolve this issue very soon. Positive resolution will come because of the hard work and efforts put in by the Congressional Office. This resolution will help to insure high quality care in Shiawassee County.

Sincerely,

Ronald K Rybar

Ronald K. Rybar
V.P. Finance

RKR/mjg

PHONE (517) 723-5211

PREPARED STATEMENT OF SISTER AUGUSTA STRATZ, ELDERLY OUTREACH WORKER, ANTRIM KALKASKA COMMUNITY MENTAL HEALTH

My name is Sister Augusta Stratz. I am the Elderly Outreach Worker for Antrim Kalkaska Community Mental Health.

Congressman Schuette, Congressional members of the Select Committee on Aging, and Task Force members: I wish to express appreciation for your time, efforts, and concerns in providing this public forum on health and aging.

It is evident that the growing number of elderly, coupled with higher use of medication and long term care services, raises many public policy issues. This nation's ability to provide adequate and affordable health care is being threatened. Americans of all ages, every day, are worried about meeting their health bills, as cost continues to spiral. For the first time, Americans are now spending more than one billion dollars a day for health care. That is a staggering amount, but by 1990, daily health expenditures are expected to rise to more than two billion.

Many elderly people in our northern rural counties are among our nation's 26 million older citizens who are with limited financial resources, with very serious disabling conditions, and those for whom catastrophic medical expenses are commonplace. Even with Medicare and Medicaid, many of the elderly who are poor or nearly poor face serious financial hardships, and even forego needed care because they cannot afford it. Rising health care cost poses a special financial burden for these elderly persons. Statistics show that the elderly spend an average of $75.00 to $100.00 per month just for medications. For the average person on Social Security, this represents a third of their monthly income. This does not take into consideration their other medical expenses. On an average, older people with low incomes have more health problems and higher rates of disability and injury than those with higher incomes. In the rules of government programs and in private insurance organizations, both the public and private sectors are deeply involved in these issues.

In the preliminary report of the ad hoc committee on health care cost containment, July 1983, it is stated in their long term strategies that:

> "There is a growing belief that improvements in our health status will not come as a result of high technology, biomedical breakthroughs, or more frequent medical intervention. Nor is it believed that improvements will occur due to an increase in the number of hospital beds or physicians. Rather, advances in health status and lowering of cost are most likely to result from the establishment of a health promotion and maintenance system, which will not only treat illness and disability, but which will prevent them from occurring. Ultimately, this will be the only effective solution to the cost of illness care. Such an approach necessarily relies on personally-initiated actions that are directly influenced by an individual's health related attitudes, values, beliefs, and knowledge. Such changes in individualistic attitudes and behaviors are most likely to occur in a society which uses collective resources to a related end."

At the local level, in keeping with the cost containment concept and the promotion of preventative health care services, we would like to identify five areas of programming and services that need to be continued and/or be developed.

1. The continuation and ongoing development of health maintenance organizations (HMO's), in the northern rural areas. We would like to see within the next five years every elderly person having access to an HMO.

2. There is a need for day care and treatment services, and respite care for the elderly. We see these as different from the present senior centers, in that each person would have an individualized plan of service and activity.

3. It is evident that there are many elderly people being labeled as having Alzheimer's disease, when there may not be a sufficient diagnostic tool available to make a diagnosis of Alzheimer's disease. In reality, many are depressed and under stress because of the effects of the aging process, such as poor eyesight, hearing loss, loss of appetite, or because of a disability they have become immobile. Also, many times physicians are not trained in gerontology and, therefore, overlook many unique characteristics of the aging person. We feel that the establishment of a gerontological center where an older person

3. (Continued) could go to be assessed physically, emotionally, and socially, would provide quality care for the older person, with the physician, nurse, and social worker being trained in gerontological aspects of aging.

4. Demographic statistics show that 12 per cent of the population are 65 and older, and this will continue to increase into the next decade. It is also evident that 33 per cent of health care service is targeted for this population, and yet few of the medical schools, nationwide, provide or encourage training in aspects of gerontology for the physicians who will be in demand to serve this target population.

5. We would like to support the recent House Bill 5200. This bill would create an older persons' prescription drug coverage program which would be administered by the State Office of Services to the Aging, through a newly established nine-member task force. This program could help older persons who fall between the cracks of other programs, presently, and/or those who have no medication coverage at all.

In summary, our nation has a responsibility, in all branches and levels of government, to form a National Public Health Policy, and to mobilize in a concerted effort our resources, both human and economic, to address the health concerns of older Americans, so that health care and service can be affordable and accessible to all.

Again, we wish to express our appreciation for the opportunity of presenting our concerns at this public hearing.

PREPARED STATEMENT OF MAXINE M. SWANSON, GRATIOT COMMUNITY HOSPITAL, ALMA, MI

Mr. Chairman, Members of the Committee, Welcome to Michigan 10. I want to thank you for the opportunity to speak before you this morning. My name is Maxine Swanson. I live in Alma and have worked at Gratiot Community Hospital for over 11 years. Utilization Management is one of my line responsibilities. I have seen the Medicare delivery system evolve from pre-PSRO Articles of Participation to the Prospective Payment System of today. Please do not consider my remarks as those of a provider only. My husband is retired and soon will become a Medicare beneficiary. My parents, recently deceased, looked to me to help them through the maze of confusing requirements and regulations.

There is no question Congress had to act to reduce massive spending. However, providing medical care to our senior citizens has become more bureaucratic and certainly more confusing to the recipients.

Michigan's PRO, Michigan Peer Review Organization, commonly referred to as MPRO, appears to be well regarded in Chicago (headquarters of HCFA, Region V). Last week, Barbara Gagel, Regional Administrator of Region V, appeared on Michigan Hospital Association's "Intelligence Report" which comes over satellite TV. She stated MPRO was one of the leaders in using what we call generic screens in judging appropriateness of admission and extended stay. In fact, the new PRO Scope of work for all of the United States will incorporate the use of such screens beginning July 1. Michigan has a higher denial rate than the national average--believed due to the use of these screens. The national rate is 3% -- Michigan's rate is 5%.

Both Region V and the Super PRO have looked at Michigan and found the denials appropriate. Their conclusion is that Michigan's rate is not too high, but rather, the rest of the nation's rate is too low. Miss Gagel further stated HCFA acknowledged patients are being discharged "quicker and sicker" but not necessarily "premature". She quoted the premature discharge rate as four one-hundredths of one percent through March of this year, stating one premature discharge was one too many -- but obviously there was not a significant problem. I agree with her. While there may be isolated cases of premature discharges, most patients of all ages are being discharged earlier and do well at home. The days of hospitalization until full functioning are over for all of us.

The problem you must be aware of is not premature discharges, which I believe to be a "smoke screen". The problem is that high admission denial rates mean hospitals receive no payment for care rendered since HCFA abolished presumptive waiver status recently.

In order to survive to serve the needs of all patients, community hospitals must reduce admissions that are at risk of being denied retrospectively. We are all struggling with how this can be accomplished. Pre-Admission Certification programs are being developed and implemented at many hospitals. Patients need to understand that if there is any question about the severity of illness or intensity of services provided while hospitalized, they will be asked to assume financial liability prior to their admission. They can exercise their right of appeal, of course.

I'd like to give you one example of a denial MPRO made in our hospital. I am prepared to give you others. But, I think this will suffice.

Picture in your mind an 84 year old male. Admission and Discharge diagnoses were dehydration, organic brain syndrom, arteriosclerotic vascular disease, plus other chronic conditions. MPRO denied the admission stating the patient could have received his IVs at home. The chart documents the patient was confused and weak, not eating at home, a worsening of his organic brain syndrome, and combative. While hospitalized, there is documentation in the chart that the patient attempted several times to pull out his IV; he succeeded in pulling the IV tubing apart one time; and was so confused, he was found several times trying to get out of bed and required restraints -- a Posey, and IM Valium one time to control his combativeness. Without fluid replacement, the patient's condition would have undoubtedly deteriorated severely. And I leave it up to your imagination what the outcome possibly could have been.

My hospital has an excellent Home Care Nursing department which has helped keep our length of stay down. It was one of the first hospital-based home care nursing departments in the state and very effective in caring for difficult cases in the home. Most of our terminal patients are discharged home to spend their last days in familiar surroundings with their loved ones -- all supported by our Home Care Nursing staff.

Citizens in rural America are facing barriers to accessing medical care. Most medical care does not require tertiary medical centers located in large cities or universities. But the victims of heart attacks, CVAs (strokes), broken bones, diabetes and other conditions common to the elderly, need prompt care furnished by friendly and familiar staff.

If hospitals are not paid for the care they render, as in the case I spoke about, they will have to either deny care, or become financially insolvent and therefore will no longer exist.

I strongly recommend HCFA require the PROs to take into account social and demographic factors in their decision making regarding admission certification. Only you and your colleagues in Congress can make that happen.

TOTAL STATE OF MICHIGAN HEALTH SERVICES, 1983-84. REPRINTED FROM THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES BIENNIEL REPORT

Submitted for the record by Representative Bill Schuette

Health care services provided in 1983 and 1984 were:

Inpatient Hospital

- room, board, medical, maternity, surgical and anesthesia services, drugs and supplies, lab and x-ray services and general nursing care
- recipients receiving services:

  —156,400 in 1983

  —151,399 in 1984
- average payment:

  —$2,872/recipient in 1983

  —$3,440/recipient in 1984

Outpatient Hospital

- medical, maternity, surgical and anesthesia services, drugs and supplies, lab and x-ray services and general nursing care for emergencies only
- recipients receiving services:

  —446,704 in 1983

  —459,040 in 1984
- average payment:

  —$119/recipient in 1983

  —$176/recipient in 1984

Home Health Care

- medical, nursing and housekeeping services in a patient's home
- recipients receiving services:

  —6,811 in 1983

  —7,881 in 1984
- average payment:

  —$696/recipient in 1983

  —$754/recipient in 1984

Physician Services

- treatment of an injury or illness in a hospital, nursing facility, physician's office or clinic
- recipients receiving services:

  —861,939 in 1983

  —844,490 in 1984
- average payment:

  —$188/recipient in 1983

  —$189/recipient in 1984

Diagnostic Services

- x-rays and laboratory tests
- recipients receiving services:

  —252,956 in 1983

  —256,362 in 1984
- average payment:

  —$67/recipient in 1984

  —$68/recipient in 1984

Pharmacy

- prescription drugs
- medical supplies needed by patients suffering from diseases such as diabetes and chronic kidney disease
- recipients receiving services:

  —774,896 in 1983

  —764,048 in 1984
- average payment:

  -$100/recipient in 1983

  —$114/recipient in 1984

Nursing Care

- nursing services in a certified facility such as a nursing home or a medical care facility
- level of care: skilled nursing is provided to patients who are less stable and require care on a daily basis; intermediate care includes less complex care such as administration of medication and observation of vital signs
- services in a skilled nursing facility:

—19,304 recipients in 1983

—18,373 recipients in 1984

- services in an intermediate care facility:

—41,351 recipients in 1983

—40,067 recipients in 1984

- average payments:

—$4,966/recipient in skilled nursing facilities in 1983

—$5,331/recipient in skilled nursing facilities in 1984

—$36,852/recipient for mentally retarded patients in intermediate care facilities in 1983

—$39,858/recipient for mentally retarded patients in intermediate care facilities in 1984

—$7,142/recipient for all other patients in intermediate care facilities in 1983

—$7,682/recipient for all other patients in intermediate care facilities in 1984

Maternity Care and Family Planning Services

- prenatal and postnatal care for mothers and their infants
- family planning services provided by physicians or family planning clinics
- recipients receiving services:

—148,931 in 1983

—150,047 in 1984

- average payment:

—$113/recipient in 1983

—$138/recipient in 1984

PREPARED STATEMENT OF PAULA WHITE, ASSISTANT DIRECTOR, MICHIGAN HOME HEALTH CARE, INC; AND CLINICAL DIRECTOR, INDIAN RIVER SUBUNIT

Committee members, senior citizens, and those interested in the welfare of seniors: I am Paula White, Assistant Director of Michigan Home Health Care, Inc. and Clinical Director of its subunit located in Indian River, serving the counties of Emmet, Cheboygan, Otsego, Charlevoix and Roscommon. Michigan Home Health Care, Inc., through its subunit in Indian River, is providing services to the Medicare/Medicaid and private insurance covered population by providing home health care services through registered nurses, physical therapists, occupational therapists, speech pathologists, social workers and home health aides. While Michigan Home Health Care is the largest home health care provider in this rural service area, it is by no means the only certified Medicare/Medicaid home care agency.

We are pleased that the committee has chosen Houghton Lake to hold a hearing and to elicit the input from the general population and provide us an opportunity to address issues which often must seem small and insignificant in Washington, but indeed are large and significant in our daily lives.

The Medicare/Medicaid skilled home health care benefit, as well as the basic care benefit funded through the aging network are almost daily experiencing new limitations and curtailments due to funding cutbacks. There is termination of services proposed by funding sources who indicate that services are not reasonable and necessary because the client's condition is not acute enough, or because there might be a spouse or family member who should provide care, or because the client is deemed not to be homebound in the eyes of the federal government. Services may also be terminated because the problem which the individual and the family is experiencing is of a chronic and slowly deteriorating nature and not of an acute character which has a rapid potential for improvement.

Services provided by the disciplines of occupational therapy, physical therapy, speech therapy and medical social workers are becoming less available to the population home health care agencies serve because the Health Care Finance Administration has chosen to develop a rule reimbursing agencies for these services at a rate which is lower than many agencies have to pay to secure those specialists in our rural areas. In the past, home health agencies were permitted to arrive at an average cost per visit, subject to a maximum amount. This approval made it possible for agencies in our area to average the costs of hirin various therapists who may be in scarce supply and thus needed to be paid a higher salary than those therapists who were more readily available and thus were less costly to the agency. This averaging of costs enabled the overall costs to remain below the maximum limit. Under the new reimbursement by discipline system the benefit of the averaging factor is lost. Many agencies have no other resources to offset the higher cost of some disciplines and are forced to abandon specialty services such as the provision of physical therapy, occupational therapy, speech therapy and most certainly social work.

The maximum reimbursement limits for health care services in home care agencies are set on a yearly basis. The rates are determined by the Health Care Financing Administration based on costs reported by all agencies nationwide on a yearly basis. We have just learned that the calculation of the 1987 rates will be based on the 1983 cost data instead of 1984 data which by now should be available. This means that the impact DRG's have had on the home health care industry since 1984, where a more acutely ill client started being served by home care agencies, will not be considered in the 1987 calculation of costs limits. This then means that agencies will be less able to provide adequate, not to mention quality service, to the rural population.

One must remember that the cost for the provision of services in someone's home is significantly higher in rural areas than in urban areas. It is entirely possible that in an urban area a nurse or therapist may see five to seven patients living in the same apartment building or in the same city block. This is not the case for the rural client. While the average miles per visit driven in an urban area ranges between two and three miles, the average miles per visit driven by rural areas, and particularly in our northern Michigan area ranges between twenty-one and twenty-eight miles. This means, not only are transportation costs higher, but the therapists or the nurses are on the road, costing the agency the same amount of money per hour for driving as if a patient were being seen. The weather conditions during the winter months in northern Michigan are extremely harsh and on many days it is not possible to see clients at all because of the existing hazardous road conditions, or the normal travel time is extended two or three fold.

The provision of twenty-four hour services, that is availability of a registered nurse to see a patient on a twenty-four hour basis, three hundred sixty five days a week, is being attempted by many of our rural home care agencies. These agencies should be commended for their efforts, but they cannot really afford the enormous cost associated with this kind of availability in view of the ever increasing restrictions in reimbursement. The question must be asked as to whether an individual, because he or she has chosen to live in a rural area, should receive less home health care services or less coverage on a twenty four hour basis compared to one's urban counterpart.

The same difficulty and cost factors faced by home care agencies are also faced by individual clients and their families when they try to secure health care.
That is, the availability of transportation and the ability to tolerate car travel for the length of time required in a rural area to gain access to outpatient clinics or physician's offices is far greater than in an urban area. Yet, when the federal government determines that a client is not homebound and is able to leave the home, it is never considered that in an urban area, a trip to an outpatient clinic or physician's office by car might take a few minutes, while in a rural area it might take one and a half or two hours.

Mr. Chairman, people living and voting in this rural area do not believe that the congressional intent of cutbacks and limited spending is to all but eliminate, or seriously jeopardize the home health care network in rural areas that over the last several years has finally been developed and put into place. We are, in this part of the country, conservative by nature, and are certainly used to self help and little, if any dependence on state or federal governmental programs. You do not hear of, and it is not common to discover fraud and abuse among rural providers or exploitation of the available system by certain segments of the public. We do believe in the entitlement program and we do believe that we are entitled to health care services in the rural areas, particularly in our homes, just as our fellow citizens are entitled, who are living in more urban areas. We find it unacceptable that a subsidized transportation system is not available to all of us, that the meals on wheels program cannot be extended to all rural citizens in need, or that the funding for the senior health screening program, which is a most effective preventive and health maintenance effort are completely eliminated for the coming fiscal year. We are concerned that home health care agencies will have to, or already have, limit the availability of specialty services such as occupational, physical and speech therapy, as well as social work because of the newly instituted reimbursement mechanism, and that providers may be unable to provide the same level and quantity of services because the funding mechanisms for the agencies and programs are driving agencies into the red. This will eventually lead to abandoning making home health care available in certain geographic areas which are especially thinly populated.

We are urging the members of the Select Committee on Aging to:

1. Support a reimbursement mechanism for home health care services in the aggregate, rather than by discipline, in order to maintain the availability of a variety of specialty services to the rural population,

2. To request of HCFA to use 1984 data from settled cost reports as a base to determine the new cost

limit for 1987, instead of the 1983 data base in order to reflect increases in costs as a consequence of DRG's resulting in a sicker population being cared for at a greater cost by home care agencies,

3. Not to support the administration's line item in the 1986-87 budget that calls for a co-payment of home health care visits by individuals who are not referred from hospitals or nursing homes, but from community settings, and not to support the administration's recommendation to limit the number of home health care visits an individual may receive per year. Both of these measures would have the greatest impact on the sickest individuals who are most in need of care and whose financial resources are the first to be exhausted. Co-payments for home health care, in addition to the Medicare deductible individuals already must meet every year, discourage care in less restrictive and less costly settings and will tempt individuals, their families and physicians, to intervene only at such time when the costs are much greater to the families and the system, and thereby society.

Mr. Chairman, I thank you for having provided us with an opportunity to testify before this committee.

MICHIGAN HOME HEALTH CARE, INC.

A PRIVATE NON-PROFIT AGENCY SERVING NORTHERN MICHIGAN

GOALS OF SERVICE

--To provide comprehensive professional health care services to ill and disabled in their own homes.
--To assist patients to attain the highest possible levels of independence.
--To teach patients and family how to maintain health and prevent complications of illness.

PROFESSIONAL SERVICES AVAILABLE

Interdisciplinary team available to persons in the home setting:

Registered Nurse	Physical Therapy	Registered Dietician
Home Health Aide	Occupational Therapy	Medical Social Worker
	Speech Therapy	

HOW TO MAKE A REFERRAL

Referral may be made by calling any office of Michigan Home Health Care. While many referrals are made by physicians and other health care professionals, anyone may make the request for home health services.

In Crawford, Roscommon, Missaukee, Ogemaw and Gladwin counties call 1-800-352-8774.

WHAT HAPPENS AFTER A REFERRAL IS MADE?

1) A nurse responds to each referral within 24 hours of referral received.
2) An assessment visit is made.
3) A plan of care is established with patient and physician approval.
4) Referrals to other disciplines are made as indicated.
5) The interdisciplinary team maintains personal contact with the patient and written &/or verbal contact with the physician on a regular basis.
6) Discharge from home health services occurs when goals of the plan of care have been met.

HOW OFTEN ARE VISITS MADE?

Visit frequency varies widely and is based on patient need and changing physical condition.

STAFF AVAILABILITY

Each MHHC office has a nurse available on-call 24 hours a day including weekends and holidays and may be reached by calling the office phone number.

FINANCING HOME HEALTH SERVICES

Most often services are covered by Medicare, Medicaid, Blue Cross or other health insurances. During the assessment visit to the home, the nurse will discuss with the patient and family the services needed, and whether such services qualify for insurance coverage. Should the patient not require services, there is no charge for the assessment visit. Every attempt is made to assist the patient and family to meet their care needs with the help of available personal and community resources. Special arrangements may be made for private payment for services if there is no other resource available.

QUESTONS, COMMENTS AND REFERRALS WELCOMED!

MHHC OFFICES

Traverse City (home office) (616) 943-8450
Indian River (616) 238-8971
Big Rapids (616) 796-3013
Ludington (616) 845-1202
Hillman (517) 742-4525

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